A qualitative exploration of acute mental health inpatient staff's experiences of working with high-risk behaviours, and the support they receive

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A thesis submitted for the degree of Doctorate in Clinical Psychology

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April 2020

Acknowledgments

I would like to thank my supervisor, Dr Lisa Wood, for her consistent support, guidance and advice throughout this project. I would also like to thank Lisa for her ongoing encouragement and her calming nature, which was invaluable during periods of panic and worry.

Additionally, I would like to thank the NHS inpatient staff who took the time to participate in this project and could share my vision of its importance. I know how busy you all are, and I appreciate the extra time you have given me to allow this project to come to life.

Most importantly, I would like to thank my friends and my parents for their unwavering support and faith in my ability to succeed. To my Mum and Dad – thank you for always being there for me, and for teaching me that with dedication, motivation and an endless supply of love, I could achieve anything I wanted to achieve.

Finally, to my wonderful Nan, who taught me to always be kind and accepting of other people. Though you may not have been here to see me over the finish line, I felt your support and pride every step of the way.

Table of Contents

Research Summary

Aims: To explore NHS acute mental health inpatient staff's experiences of working with high-risk behaviours, and what support they receive following exposure to these incidents.

Background: Staff working in acute mental health inpatient environments are frequently exposed to high-risk behaviours. Emerging research indicates this can leave staff with symptoms of anxiety, post-traumatic stress disorder and burn-out. Considering the high rates of staff turnover in these environments, the findings are important in understanding how the strain of day-to-day ward experiences can affect staff. However, little is known about the personal impact of working with high-risk behaviours, or what support is available following these incidents.

Methodology: This study utilised a qualitative methodology with a constructionist lens. 10 participants were recruited from two NHS mental health Trusts in England. Data was gathered using semi-structured interviews, and analysed using inductive thematic analysis methods.

Results: Three main themes emerged: the direct impact of incidents, attempts to manage the impact of incidents and current systems for managing incidents. Staff exposed to violence and aggression felt on edge and unsafe at work. Attempts to mitigate the personal impact of this included 'just getting on with it', and remembering that the patients are unwell. Exposure to self-harm and suicide ideation left staff feeling emotionally overwhelmed, deskilled and demotivated. They described higher levels of their own emotional distress as a response to these incidents. Overall, staff felt that support was lacking, and there was a fear that seeking support was a sign of weakness.

Conclusion: Clear differences in staff reactions and responses to varying high-risk behaviours were revealed. Support for staff was lacking, which led to unhelpful narratives that spanned ward and management levels. These findings are discussed in relation to existing literature and psychological theories. The clinical implications of this study and directions for future research are explored.

Chapter One: Introduction

1.0 Chapter Overview

The present study explores National Health Service (NHS) acute mental health inpatient staff experiences of exposure to high-risk behaviours such as violence, aggression, self-harm and suicide ideation, and what support they receive in relation to this. This chapter comprises seven sections: the context of NHS mental health inpatient settings, therapeutic relationships, the nature of violence and aggression, the nature of self-harm and suicide ideation, theoretical underpinnings, a systematic review exploring current literature on this subject area and an overview of the aims and questions of the present study.

1.1 Part I: National Health Service (NHS) inpatient mental health services

1.1.1 History of inpatient mental health services

The first ‘hospital for the insane’ in the United Kingdom was commissioned in 1676, and from here many asylums were built in order to provide compulsory detention of patients, many of whom were labelled as either ‘curable’ or ‘incurable’, and whose conditions were not well understood (Killaspy, 2007). Mental ill health was deemed a societal rather than a medical issue, therefore people would often be admitted for displaying behaviour deemed as ‘wild’ or ‘extreme’, often towards others or property, and also included the poor, disabled and those with conditions such as epilepsy (Dickinson, 1990). Treatment was often poor, and included confinement, stimulation (using cold baths, electric shocks and rotating and spinning devices) immobilisation (handcuffs, shackles and straightjackets) and bloodletting.

Following the establishment of the National Health Service (NHS) in 1948, and a change in the social and political climate, it was recognised that keeping patients in hospital once they were well enough to go home was an infringement of their human rights. The Mental Health Act of 1959 was the first mental health legislation in the UK to outline the conditions under which people might be admitted to hospital against their will, and attention turned to the consequences of institutionalisation and poor care for mental health patients (Goffman, 1968), leading to the gradual closure of asylums.

1.1.2 Current inpatient mental health service provision

Today, the purpose of acute adult inpatient mental health services is to provide humane treatment and care, within a therapeutic setting, for individuals who cannot be appropriately supported in the community due to the nature of their mental health needs and risk (Department of Health, 2002). Within England, there were 18,082 overnight beds available for 'mental illness' in 2017/2018 (NHS England, 2018), the care within which is supported by national standards, guidelines and frameworks, such as the Department of Health, the Mental Health Act, the Mental Capacity Act and National Institute for Health and Care Excellence (NICE) guidelines. In 2018/2019, 62% of occupied beds were used for people with a diagnosis of psychosis, and the average length of stay was 31.6 days (NHS Benchmarking, 2019).

The majority of patients in NHS secure hospitals are detained under the Mental Health Act (1983, 2007) for being deemed to pose a significant risk to themselves or others. Detention involves assessment by two registered medical professionals who

deem the individual to be experiencing mental health difficulties to the extent that they require inpatient assessment or treatment, and it is felt that this cannot be provided in the community (Mental Health Act, 1983, 2007). More recently there has been increased focus on providing mental health support to adults in the community, and the current NHS long term plan aims to provide primary care and community based treatments to 370,000 adults with severe mental illnesses (psychosis, bipolar disorder, personality disorders, eating disorder and severe depression) by 2023/24 (NHS England, 2019), reducing the need for admission to hospital. Despite this, there were 49,551 reported new detentions under the mental health act in 2017/18, an increase of 2.4% from the previous year (NHS Digital, 2019), suggesting a disparity between the goals of providing effective community treatment and the complex health needs of adults experiencing mental health difficulties.

1.1.3 Security

Although there is increased focus on providing community mental health care to adults with severe mental illnesses, the number of detentions under the Mental Health Act (1983, 2007) continues to rise. A key factor for detention concerns the level of risk that the individual poses to themselves or others. Therefore, it could be argued that the safety and security of staff and patients in mental health inpatient services is a top priority. Inpatient services manage security in three key areas: physical security, designed to keep people physically safe through the use of locked doors and personal alarms, procedural security, designed to keep people safe through the use of policies and procedures, and relational security, designed to keep people safe through staff knowledge and understanding of the patient and their environment, and is influenced by factors such as staffing levels, time spent with patients and the ward environment

(Department of Health, 2010). Despite this, many patients have reported that inpatient services offer an inadequate physical and psychological care environment, including feeling unsafe (Department of Health, 2002). Additionally, the high bed occupancy and increasing complexities of patients on the wards can increase the pressure on staff to maintain their own and patient safety, reducing their ability to engage meaningfully and therapeutically. This lack of safety and engagement can lead to inpatient environments that feel volatile for both staff and patients, impacting on the ability to provide therapeutic care and creating a work environment that is challenging to manage (Quirk & Lelliott, 2001).

1.1.4 Care and control

Balancing the need for safety and security within a therapeutic environment can be a challenge for staff. Acute mental health inpatient staff are faced with the unique dilemma of helping to create a caring and therapeutic environment whilst holding knowledge that they may be required to deploy physical or chemical restraint (through the use of medication and pharmacological treatment) to patients. It is acknowledged in the literature that restraint is used as an intervention to protect patients from harming themselves or others (Gelkopf, et al., 2009), however the Mental Capacity Act (2005) stipulates that this should only occur if staff believe it is necessary and proportionate to the harm that could be caused from not doing so. Whilst designed to be a protective intervention, it appears that staff and patients alike consider this a stressful and coercive act (Morales & Duphorne, 1995) which can negatively impact on staff, patients and the ward environment as a whole (Marangos-Frost & Wells, 2000). As such, there has been a move towards reducing the use of restrictive practice in acute mental health inpatient services. Recent research has

advocated for the use of behavioural support plans, devised by the multidisciplinary team, to reduce the need for restraint, seclusion and rapid tranquilisation (Clark, Shurmer, Kowara & Nnatu, 2017). These plans utilise a biopsychopharmacosocial (BPPS) approach exploring a patients biological, psychological, social and pharmacological factors which may contribute to high-risk behaviours, and this information is used to form a management plan detailing least to most restrictive interventions (Clark et al., 2017).

1.2 Part II: Therapeutic relationships

It is acknowledged that an inadequate care environment can cause patients and staff to feel unsafe, which can negatively impact on the therapeutic quality of staff and patient relationships (Department of Health, 2002; Quirk & Lelliot 2001). For those reasons, it is necessary to explore how therapeutic relationships can impact on staff and patient experiences of the inpatient environment. Therapeutic relationships are important in establishing collaborative care and treatment plans, and ensuring that patients maintain a sense of meaning and control over their situation, which in turn can have positive treatment outcomes (McCabe & Priebe, 2004). In acute inpatient mental health settings, poor therapeutic relationships, as a result of lack of engagement with staff, has led to an increase in challenging behaviours, and a decrease in social engagement (Fairbanks et al., 1977). Therefore, it is important to understand how the therapeutic relationship between staff and patients can impact on patient care, and on staff competencies in meeting the needs of the patients they work with.

1.2.1 Defining therapeutic relationships

The therapeutic relationship describes the subtleties between the provider and the receiver of care (Freud, 1912). In psychoanalytic terms, the therapeutic relationship is proposed to comprise of three parts: the working alliance, transference and countertransference, and the real relationship (Gelso & Carter, 1994). Differing from social relationships, therapeutic relationships focus on the needs and goals of the patient and concentrate on facilitating communication of difficult experiences, assisting patients with problem solving, helping patients to explore their current behaviours and promoting independence (Varcarolis, 2006).

1.2.2 Importance of therapeutic relationships

The development of therapeutic relationships is an important part of inpatient care, and ruptures to these relationships can have negative consequences for staff and patients alike. Rogers (1957) proposed that in order for therapeutic change to occur within a patient, the therapist must display genuineness, empathy and unconditional positive regard, and indeed it could be argued that this extends to the therapeutic relationship between all inpatient staff members and patients. If the goal of inpatient admission is to provide a therapeutic space to allow for recovery to take place, then it is essential that staff can adopt these qualities in to their own working practice. Indeed, Weir (1992) acknowledged that staff could be considered ‘therapeutic agents’ for patients, and that spending time developing positive therapeutic relationships with patients should be seen as a moral commitment to interpersonal care (O’Brien, 2001).

Despite this, staff working in acute mental health inpatient settings report struggling to develop positive therapeutic relationships with patients. On a practical level,

nursing staff in particular report that the increase in their administrative duties hinders their ability to spend quality time with patients, further impeded by the high patient to nurse ratio (Hopkins, Loeb & Fick, 2009; Sharac et al., 2010). Additionally, nurses felt that working in an unpredictable environment and the fear of being physically assaulted damaged their ability to connect positively with patients (Camuccio, Chambers, Välimäki, Farro, & Zanotti, 2012; Ward, 2013). Furthermore, nurses feel that they do not have the time to provide the levels of person-centred care that each individual patient needs, and felt conflicted in their duties to provide therapeutic nursing care whilst also maintaining social control through restraint and seclusion procedures (Hopkins et al., 2009; Shattell, Andes & Thomas, 2008). Given the importance of positive therapeutic relationships in promoting the recovery of patients, and reducing the likelihood of patients displaying high-risk behaviours, it seems important to understand how nurses, and other frontline staff in mental health inpatient services, can be supported to feel safe and effective in their work environment, and overcome some of these barriers to working in a challenging and demanding setting. Indeed, a systematic review by Hartley, Raphael, Lovell and Berry (2019) found that there is a scarcity of research in this area. There was some evidence that addressing staff attitudes and increasing reflective capacity and relational understanding might be useful. However, it was also acknowledged that the literature tended to focus on one dyadic relationship, rather than exploring the difficulty of establishing therapeutic relationships that span multiple professionals in varying roles, and the complexities this brings to the development and maintenance of the therapeutic relationship.

1.3 Part III: High-risk behaviours

1.3.1 Overview of high-risk behaviours

It appears that inpatient environments that feel controlling, coercive, and lacking in therapeutic engagement can impact on levels of high-risk behaviours (Fairbanks et al., 1977; Marangos-Frost & Wells, 2000). The presence of high-risk behaviours means that maintaining the safety of staff and patients is a key feature of acute mental health inpatient nursing (Slemon, Jenkins & Bungay, 2017). This involves ongoing assessment and management of risk through the use of approved organisational interventions. Typically, patients sectioned under the mental health act are deemed to be at risk to themselves or others, and are therefore likely to display high-risk behaviours that include violence, aggression, self-harm and suicide ideation. These high-risk behaviours, and relevant documentation concerning their relation to acute inpatient mental health care, are discussed here.

1.3.2 Violence and aggression

High-risk behaviours concerning violence and aggression on acute mental health inpatient wards are discussed here, along with the current guidance for managing these high-risk behaviours.

1.3.2.1 Definitions of violence and aggression

When exploring incidents of violence and aggression, it can be important to distinguish between the two terms. Defining violence and aggression can be problematic for researchers, as terms are often used interchangeably despite the two constructs being considered different psychological phenomena (Rippon, 2000).

Furthermore, there does not appear to be one clear definition of what constitutes either violence or aggression, and verbal abuse has only relatively recently been acknowledged as having an impact on staff (Adams & Whittington, 1995). Bandura (1973) defined aggression as behaviour that can result in physical or psychological injury, or destruction of an object. He also noted that although injury is seen to be a major defining factor of aggression, not all injurious or destructive acts are viewed as aggressive, and there is some influence of the judgement others make of the behaviour being displayed that deems it to be aggressive, or not. Whilst there seems to be some element of subjectivity within definitions of aggression, definitions of violence appear to be more robust. The World Health Organisation (WHO) defines violence as the threatened or actual intentional use of physical force or power against oneself, another, group or community that is likely to result in physical or psychological injury, death, maldevelopment or deprivation. In other words, violence could be summarised as the intentional actual or threatened harm to an individual or group of people. From both definitions, it is easy to see how and why terminology is used interchangeably, and will be something for this research to be considerate of during data collection and analysis.

1.3.2.2 Violence and aggression within mental health services

Violence and aggression are considered common occurrences within mental health services, most frequently occurring in inpatient settings (NICE, 2015). NHS Protect (2016) reported that for 2015/2016 there were 46,107 physical assaults on staff working in the mental health sector, equivalent to 191 physical assaults per 1000 staff. These figures, however, cannot account for the number of times staff were exposed to verbal abuse, and are likely to be an underrepresentation of the actual

figures as there seems to be a rhetoric that abuse is ‘part of the job’ (Pejic, 2005) within services. Indeed, a study by Bowers, Simpson and Alexander (2003) found that staff were most frequently subject to verbal aggression, followed by patient displays of physical aggression towards objects, and then towards others.

A number of patient, staff and environmental factors are thought to be related to the presence of violence and aggression within inpatient units (Owen, Tarantello, Jones & Tennant, 1998), although the findings in these areas are inconsistent. Early studies of patient factors contributing to the risk of violence and aggression suggested that a diagnosis of schizophrenia (Pearson, Wilmot & Padi, 1986), experiencing delusions and hallucinations (Noble & Rodger, 1989), being younger at the time of admission (James, Fineberg & Shah, 1990) and being male (Pearson et al., 1986) increased the likelihood of displays of violent or aggressive behaviour, however, more recent studies have not supported these findings (Cooper & Mendonca, 1991; Whittington & Patterson, 1996). This is similarly the case for staff factors, where findings have suggested that being less experienced and male meant an individual was more likely to be assaulted at work (Baxter, Hafner & Holme, 1992), though this was not supported by later studies (Adams & Whittington, 1995; Wynn & Bratlid, 1998).

Indeed, a more likely contributing factor of patient displays of violence and aggression appears to be the ward environment itself, and the impact this has on staff and patient therapeutic relationships (Shepherd & Lavender, 1999). Patients report that feeling powerless is a contributing factor for violence and aggressive behaviours (Johnson, Martin, Guha & Montgomery, 1997), impacted by a ward culture that feels rigid and controlling (Katz & Kirkland, 1990). NICE (2015) guidance promotes de-

escalation techniques in the first instance, with manual and chemical restraint, and seclusion, only occurring if attempts to verbally de-escalate have been unsuccessful. However, given the daily challenges that both staff and patients face in being in a high-risk and unsafe feeling environment, it would not be surprising if attempts at verbal de-escalation were ineffective. Perhaps, therefore, incidents of violence and aggression should be viewed in the ward contexts in which they occur, with a focus on addressing the ward climate and culture, rather than attempting to make links between staff and patient characteristics and incidents of violence and aggression.

1.3.3 Self-harm and suicide

As well as incidents of violence and aggression, inpatient staff may also be faced with exposure to self-harm and suicide ideation from patients. High-risk behaviours concerning self-harm and suicide on acute mental health inpatient wards are discussed here, along with literature exploring attempts to manage these high-risk behaviours.

1.3.3.1 Definitions of self-harm and suicide

Similarly with violence and aggression, it is important to clarify the distinction between self-harm and suicide behaviours when exploring this area in research. Self-harm refers to any act of self-poisoning or self-injury carried out by a person, regardless of their motivation or intent (NICE, 2013). Whilst an act of self-harm is not necessarily an attempt at suicide (Royal College of Psychiatrists, 2010), this may be an outcome of self-harm. Suicide refers to the intentional ending of one's life. Therefore, for the purpose of this research self-harm will also include suicide

attempts that were not completed and did not result in death, and suicide will be used only when a patient's attempt at suicide results in their death.

1.3.3.2 Self-harm and suicide within inpatient mental health services

Self-harm and suicide ideation are behaviours seen in inpatient and community services alike, and can be a contributing factor to detention under the Mental Health Act (1983, 2007). Approximately 220,000 people attend accident and emergency departments in the UK following an episode of self-harm every year (Hawton et al., 2007). A systemic review by James, Stewart and Bowers (2012) found that within inpatient units cutting was the most common form of self-harm, followed by head banging, punching and kicking, strangulation, insertion of foreign objects in to the body, re-opening old wounds, burning, self-poisoning, biting, electrocution and hunger strike. People most often appear to self-harm in private areas, such as in bathrooms and bedrooms, and during the evening (Nijman & Campo, 2002). There were a number of triggers for self-harm, most commonly cited as psychological distress, but also factors relating to care, such as seclusion, feeling controlled by staff and disruption on the ward (James et al., 2012). The Department of Health (2001) reported that inpatient suicide accounted for 16% of all completed suicides. There are a number of long- and short-term risk factors associated with inpatient suicide. Long-term factors include previous suicide attempts, suicidal thoughts, feelings of hopelessness, being male, multiple admissions to inpatient care and a longer stay of admission; short-term factors included symptom severity, the appearance of 'clinical improvement', insight (both a lack of, and a good understanding of their condition), substance abuse, non-compliance with treatment, and social factors such as a lack of social support (Cassells, Paterson, Dowding & Morrison, 2005).

The management of self-harm and suicide ideation on inpatient mental health wards continues to attract attention. Paterson et al., (2008) found a high degree of variance among doctors and nursing staff assessing for risk of suicide in patients. This uncertainty can lead to restrictive practice through the use of continuous observations, the usefulness of which has been contested. With the shift of maintaining safety being on staff, some patients describe feeling punished and powerless, further contributing to their desire to self-harm (Taylor, Hawton, Fortune & Kapur, 2009). Those who found observations beneficial reported that being given some responsibility for preventing their own self-harm, as well as being engaged and occupied by the staff carrying out their observations, contributed to increased feelings of being in control of their situation. Therefore, it might be useful to address staff attitudes and feelings towards working with patients who self-harm, and encourage a collaborative approach to the management of these behaviours that serves to reduce the lack of certainty staff can feel in keeping patients safe, and can foster a sense of control and responsibility in patients that can help them to view their treatment as therapeutic rather than punishing.

1.4 Part IV: Theoretical Links

The aforementioned research suggests that individual factors, the ward environment and organisational cultures contribute to the presence of high-risk behaviours in inpatient mental health services. Therefore, it makes sense that a theoretical understanding of staff experiences of high-risk behaviours, and the impact this has on them, should incorporate both individual and group perspectives. Social rank theory

can be used to understand how individuals are required to modulate their reactions to these incidents, depending on the culture of the wider staff group on the ward and what is deemed as a desirable or acceptable reaction to risk. In addition, the multidimensional theory of burnout helps to explain how individual stress experiences are embedded in complex social contexts, and that individual experiences are therefore influenced by the person's conception of themselves and others within a given context. Together, these perspectives can help to formulate an understanding of the impact of high-risk behaviours on acute mental health inpatient staff and the cultures within which they work.

1.4.1 Social Rank Theory

Social Rank Theory offers an evolutionary understanding of human behaviour and psychopathology. Gilbert (2001) proposes that Social Rank Theory explains how individuals are required to compete for 'attractiveness', or a higher social status, in order to elicit approval, support and care from others. When individuals perceive themselves to be of a low status within the hierarchy, or at risk of losing status, they engage in behaviours designed to be protective of their status (Gilbert, 2001), however these behaviours can also run the risk of doing damage by appearing unattractive or undesirable to others.

From an evolutionary perspective, the competition for territory shifted to competition for social rank when mammals started to live together in groups, as those who exerted higher levels of dominance had better access to resources, such as food and mates, than those of a lower social ranking (Tse, Wu & Poon, 2011). Additionally, those who held more dominant positions also had the power to administer rewards and

punishments to the rest of the hierarchy (Weisman, Aderka, Marom, Hermesh & Gilboa-Schechtman, 2011). These same hierarchy rankings of power and social status, and the ability to reward or punish those lower in the social rank, can be seen in human groupings today, such as in the case of employer-employee relationships, and in the case of this present study, staff-patient relationships.

Therefore, Social Rank Theory can be used to understand how exposure to high-risk incidents can impact on staff on an individual and group level. Within inpatient services, staff members are deemed to be in a more powerful position than the patients in their care, namely through being in control of the patients and their freedom (Johansson, Skärsäter, & Danielson, 2006; Main, McBride, & Austin, 1991). This gives staff higher social ranking than the patients. However, patients can threaten to displace this social ranking through threats, violence and close monitoring of staff activity (Johansson et al., 2006). For staff in inpatient environments, the sense of threat is persistent, displayed through frequent high-risk behaviours (Kelly, Fenwick, Brekke & Novaco, 2016). This means that staff are at constant risk of losing their social rank status, and so must continuously monitor their ranking against patients and colleagues, known as insecure striving (Gilbert, McEwan, Bellow, Mils & Gale, 2009). This continued need to assess rank and compete for hierarchical status can cause staff to feel that they are low rank, or at risk of becoming low rank, which has negative consequences at both individual and group levels (Fournier, Moskowitz & Zuroff, 2002).

From an individual perspective, the threat of losing social status can lead to feelings of shame, failure, depression and incompetence (Andrews & Brewin, 1990; Gilbert &

Miles, 2000), known factors contributing to burnout in inpatient staff (Crabbe, Alexander, Klein, Walker & Sinclair, 2002). Additionally, the 'at risk' staff member must work to preserve their status on a group level, by showing desirable responses to the incident. They must respond in a way that shows competence and authority over the patient's behaviour in order to maintain control and power, whilst also working in line with qualities deemed attractive by their colleagues (Fournier et al., 2002). In some instances, this may involve refraining from expressing the impact of their experiences, in favour of aligning with the narrative of the group, or to comply with those in higher positions (Fournier et el., 2002). Therefore, Social Rank Theory can explain how repeated exposure to high-risk behaviours can lead to feelings of low-morale, failure and incompetence in inpatient staff. It can also explain how staff may suppress the impact of these feelings in an attempt to align with the ward narrative, maintaining their position in the dominant group.

The importance of the safety of the system should also be acknowledged when thinking about Social Rank Theory. Rather than viewing society as a competitive space, safety is preserved when the system works within a co-operative framework. Therefore, the system searches for allies with which to connect, evaluating the levels of sameness and difference that an individual possesses in relation to the system so that accurate in-group versus out-group distinctions can be made (Giammarino & Parad, 1986). An individual's level of belonging to the group depends on their ability to conform to group standards, and has become central to physical and mental health within humans, as well as having important consequences for self-esteem and self-identity (Abrams, Wetherell, Cochrane, Hogg & Turner, 1990; Gilbert & Miles, 2000). It is because of this importance to belong to a group that judgements of social rank and belonging are linked.

Belonging to a hierarchy or a group is characterised by two different behavioural styles, agonistic and hedonistic behaviour. Agonistic behaviour focuses on aggression, including the inhibition of aggressive behaviour, whereas hedonistic behaviour focuses on co-operation. Agonistic behaviour requires an individual to evaluate their own potential against the potential of the individual who poses the threat. The sense of threat will often result in an innate fight or flight response, however, humans often have to adapt this response due to constraints around being able to escape from every threatening situation they encounter (Gilbert, 2001). Additionally, individuals will be battling with ensuring they remain part of the in-group and appear desirable to others, making the choice of reaction even more important. Using a display of patient aggression as an example, the staff member may acknowledge that they need to inhibit their own instinct to fight back. Through displaying aggression, the patient has exerted a degree of threat and dominance over the staff member, meaning that the staff member is at risk of having their social rank displaced (assuming the rhetoric within inpatient units follows that staff members are in control of the patients and the ward). The staff member is working within professional conduct guidelines, and so is not at liberty to directly challenge the patient by fighting back, so must act to prevent the assault through means of restraint, thereby stopping the attack and establishing dominance over the patient through means of immobilisation. The hierarchy of the ward in maintained, and the staff member is able to keep their social rank status by demonstrating desirable qualities to the rest of the staff team. However, the inhibition of the fight response sometimes comes at a cost to the individual, and may lead to negative consequences such as a loss of energy, sleep disturbance and loss of confidence (Gilbert, 2001), reflecting

other widely reported staff experiences in the inpatient setting such as high levels of staff burnout (Crabbe et al., 2002).

Hedonistic behaviour requires an individual to demonstrate qualities that will benefit the in-group through being deemed as attractive. The approval of these qualities helps to raise self-esteem and confirm positive social ranking, whereas disapproval can result in a loss of status, reduced self-esteem and loss of attractiveness to the in-group (Kalma, 1991). In order to maintain control and hierarchy in the inpatient environment, staff teams need to work together to build an in-group that works effectively to support one another and keep the ward environment safe. Behaviours which appear to deviate from this, or poorly managed incidents of violence, aggression and self-harm, can be seen as non-conforming to the in-group, and the resulting disapproval or lack of support from others may help to explain why some staff experience feelings of incompetence, or blame themselves for the incident (Andrews & Brewin, 1990; Gilbert & Miles, 2000).

Whilst social rank theory can help to explain behaviour in the context of social groups and desirability, its application to acute inpatient mental health units is not straight forward. It is important to remember that multi-disciplinary teams are made up of professionals with varying levels of qualifications, and as such, differing levels of social status (Lichtenstein, Alexander, McCarthy & Wells, 2004). This pre-determined concept of status and power within inpatient teams can impact on how different members of staff feel they can influence and respond to the ward environment (Alderfer & Smith, 1982). Therefore, despite being part of the in-group, and being tasked with the job of maintaining a safe and therapeutic environment,

members within the in-group itself can feel more or less valued, and more or less influential, in their work. This can lead to chronic feelings of inferiority for less qualified members of the in-group, leading to submissive and obedient behaviours in an attempt to avoid criticism or negative judgement from those with higher ranking (Fournier, Moskowitz & Zuroff, 2002). It is possible, then, that individuals of lower status exposed to high-risk incidents on the ward may attempt to deny the personal impact this has had on them and may avoid seeking support in order to demonstrate that, despite their lower ranking, they are capable allies and worthy of in-group membership (Fournier et al., 2002). This is problematic, as it can lead to a culture of denial and create an environment that is resistant to change. To attempt to mitigate against this, it has been suggested that team leaders should be selected based on their abilities to support open and honest communication throughout the team, rather than on professional hierarchy (Lichtenstein et al., 2004). Furthermore, this is suggestive that social rank theory alone is not sufficient in explaining the experience of high-risk incidents on the wards, and what impact this has on both individual members of staff and staff teams as a whole, but rather that there are other unconscious factors at play which need to be considered when exploring staff experiences in this environment.

1.4.2 Multidimensional Theory of Burnout

The low-morale and feelings of incompetence experienced by staff from a Social Rank perspective can also be explained and built upon by the Multidimensional Theory of Burnout. Burnout can occur as a result of emotional exhaustion, depersonalisation and reduced personal accomplishment, and is often seen in professional contexts where staff are required to provide a service to others by doing ‘people work’, such as hospital settings (Maslach, 1982). What is unique to burnout,

as opposed to other types of job stress, is that it directly arises as a result of social interactions and is a response to chronic everyday stress.

Levels of burnout are high within inpatient mental health settings, and pose an ongoing issue for staff teams and organisations (Morse, Salyers, Rollins, Monroe-DeVita & Pfahler, 2012). Therefore, it can be helpful to acknowledge the link between exposure to high-risk behaviours, and burnout in staff. The Multidimensional Theory of Burnout helps to address this link, but explaining how high-risk behaviours can impact on staff from an emotional and professional perspective. Staff in inpatient mental health settings are frequently exposed to high-risk incidents which require careful management and cohesive group working among colleagues (Sullivan, 1993; Trygstad, 1986). When the presence and management of these high-risk behaviours becomes overwhelming, staff may defend against this by becoming emotionally detached from their work (Menzies, 1960). This can have negative consequences for staff on a personal level, feeling depleted and exhausted, and professionally, by feeling incompetent and lacking personal accomplishment (Maslach, 1998). As such, burnout is considered to be the result of emotional exhaustion, depersonalisation and reduced personal accomplishment, factors which can arise from the exposure to and daily management of high-risk incidents on inpatient wards.

The first stage of burnout, emotional exhaustion, is characterised by staff feeling emotionally overextended and depleted of personal emotional resources (Maslach, 1998). The main sources of emotional exhaustion are a high workload and personal conflict at work. In the acute mental health inpatient setting this can include the

increasing amounts of administrative tasks staff are required to do (Dawkins, Depp & Selzer, 1985), inadequate levels of staffing (Carson, Leary, de Villiers, Fagin & Radmall, 1995), the management of high-risk behaviours (Sullivan, 1993) and conflicts between staff (Trygstad, 1986). In response to the feelings of emotional exhaustion, staff may engage in 'professional detachment' as a way to protect themselves against the emotional aspect of the work (Menzies, 1960). However, this can have negative consequences for the patients that staff work with, as this detachment can lead to depersonalisation, where patients are seen as a particular 'case' or 'symptom', rather than as an individual who is experiencing distress (Maslach, 1998). This detachment and task orientated way of working can lead to reduced feelings of personal accomplishment, where staff negatively and critically appraise their own abilities and competence at work (Maslach, 1998). It is believed that reduced personal accomplishment develops alongside emotional exhaustion and depersonalisation, rather than being a sequential process (Leiter, 1993).

Research has demonstrated that experiences of burnout among mental health staff can be mitigated against and reduced by the provision of support, which includes emotional support (though showing sympathy and care towards staff members) and practical support, such as providing assistance with the workload (Fenlason & Beehr, 1994), and high levels of support have also been shown to be associated with lower levels of burnout in staff (Sullivan, 1993). Therefore, it is important that research in this area focuses on the ward culture, and organisational attitude, towards staff expression of their own distress in working with highly complex patients, in order to promote reflective practice among individual staff members, staff teams and whole organisations. Without this, it is unlikely that staff will be able to connect

therapeutically with the patients they work with, and effectively manage their own wellbeing in response to this, and may further contribute to the high levels of stress and turnover in inpatients settings.

1.5 Part V: Systematic Review

The literature explored so far highlights that staff working in acute mental health inpatient services are likely to be confronted with high-risk incidents on a daily basis. Managing these incidents can be difficult and places great pressure on staff, which has implications on their ability to form therapeutic relationships with patients and can result in a task focused rather than person centred environment. Furthermore, it seems that the impact of this work on staff can be difficult to explore within teams and organisations. Perhaps the reluctance to acknowledge the emotional consequences of this type of work can help to explain the dearth of research in to staff experiences in this area. It is not surprising, therefore, that literature exploring staff experiences in this area has not been synthesised. As such, the aim of this systematic review is to examine and unite the literature concerning staff experiences of exposure to patient violence, aggression, self-harm and suicide ideation. It also aims to identify whether staff experience working in these environments receive any post-incident support.

1.5.1 Article identification

The databases Web of Science, Medline, CINAHL, psycINFO and psycARTICLES were initially searched for literature in January 2019, and updated in January 2020. OpenGrey was also used to search through the grey literature at this time.

Additionally, the reference lists of articles included in the systematic review were searched for any further papers that may have been relevant to the review. A search strategy identifying references related to the exposure of inpatient staff was used, outlining relevant inclusion and exclusion criteria. The terms 'NHS' and 'National Health Service' were not included in the search terms, as it was felt that these would limit the scope of the search and relevant papers may be missed if those terms were not included in the titles and abstracts of the papers. No date limit was set for the searches, and both qualitative and quantitative papers were included to allow for the maximum inclusion of potential articles for review. The full search strategy and results are listed in Appendix A. As a result of this procedure, ten articles were deemed appropriate for inclusion in the review (Appendix B).

1.5.2 Quality appraisal

Slavin (1987) proposed that systematic reviews should only include high-quality articles. Others, however, have suggested that all studies appropriate to the review should be included (McPherson & Armstrong, 2012). Nonetheless, it is important to provide a quality assessment of the articles included in the review, to allow the reader to interpret these findings in line with specific parameters (Schlosser, 2007). Due to the limited literature available in this area, no articles were excluded from this review on the basis of quality.

There has been some debate, and a general lack of consensus, over assessing the quality of qualitative literature. It has been argued that it is not appropriate to apply quantitative ideas to qualitative research, due to their differing positions concerning ontological and epistemological assumptions (Smith, 1984). Despite this, some

researchers have argued that it remains important to review concepts related to bias, validity and reliability in qualitative research (Morse, Barrett, Mayan, Olson & Spiers, 2002).

As this review included both quantitative and qualitative articles, the QualSyst tool (Kmet, Lee & Cook, 2004) was chosen to provide quality appraisal. QualSyst comprises of two systems, one focused on appraising quantitative research, and the other qualitative. Unique criteria in each system are scored as either not applicable (-), not fulfilled (0), partially fulfilled (1) or fulfilled (2). The overall score is calculated as the total sum/total possible sum, with a final score falling between 0 and 1. The scoring system is the same across both systems, though the criteria differs according to what is deemed important for the methodology used. For example, the quantitative system asks for assessments of the use of random allocation, researcher blinding, appropriate sample size and the use of robust outcome measures, whereas the qualitative system concerns itself with whether there is a connection to a theoretical framework, if verification measures are used to establish credibility, and whether a reflexive account is included. By creating a system where both quantitative and qualitative research can be scored in the same way, the QualSyst tool allows researchers to simultaneously assess a wide range of study designs that have a comparable scored outcome. However, it should be noted that inter-rater agreement varied for both quantitative (73-100%) and qualitative (60-100%) studies, suggesting that quality assessments should be interpreted with caution (Kmet et al., 2004). The quality appraisal information for the articles included in this review can be found in Appendix C.

1.5.3 Data Synthesis

Narrative synthesis is an approach that can be used to summarise and explain the findings of both quantitative and qualitative data, and is therefore a useful approach for systematic reviews combining both methodologies. The unique characteristic of this approach is that it uses a textual method to 'tell a story' about the statistical data presented in the review, allowing it to be understood alongside qualitative research (Popay et al., 2006). As this review includes both quantitative and qualitative data, this approach was deemed appropriate in analysing the articles in a way that could bring together an overall understanding of the current knowledge in this area, allowing the different methodologies to complement each other and contribute to the knowledge base.

The narrative synthesis was carried out using guidance from Popay et al., (2006), who suggest four elements to be carried out as part of the synthesis process. The first element, *developing a theoretical model*, seems more fitting when the focus of the review is to understand the effectiveness or implementation of an intervention, understanding how they work, why and for whom. However, as part of the purpose of this step is to inform decisions about the research question, the theoretical basis for this study involved explaining staff experiences of the inpatient setting. This model is then used during the planning and article selection stage of the review to determine which studies to include, and contributes to later interpretations of the findings and their applicability to inpatient mental health services.

The second element, *developing a preliminary synthesis,* is concerned with establishing an initial description of the results of the studies included in the review. The purpose of this is to identify and begin to explore relationships across the data. Quantitative and qualitative data was integrated through identifying common areas of exploration across the data. For example, participant experiences of post-traumatic stress disorder, as gathered by interview techniques, were complemented and supported by qualitative data indicating that participants demonstrated clinically significant symptoms on outcome measures, suggesting that experiences of high-risk incidents have both a subjective and clinically measurable impact on staff.

As patterns begin to emerge from the preliminary synthesis, the third element, *exploring relationships in the data,* focuses on "rigorous interrogation" (Popay et al., 2006) to identify differences and similarities across the data, and identifies any factors for why these might occur. This involves looking at the heterogeneity of the studies included in the review, and the impact this might have on the findings. Whilst the obvious difference between quantitative and qualitative articles concerns the methods of data collection, this review also explored the impact of context and job role on the data presented in this review, and what impact this might have had on the findings. A number of different techniques can be used during this step, and this review focused on thematic analysis as a way of extracting themes from the data that directly reflects, through an indictive approach, the main ideas and conclusions of the studies (Popay et al., 2006). This was conducted following guidance from Braun and Clarke (2006), where data is systematically coded and grouped in to themes, which are then reviewed against the data to ensure they are reflective and representative of the content.

The final step, *assessing the robustness of the synthesis,* explores how the quality of the studies included in the review impacts on the outcome of the synthesis. This helps to identify if the overall conclusions of the review can be said to representative of the data presented, and whether they might be generalisable to similar contexts or populations, supported by the results of the quality appraisal tool.

1.5.4 Systematic review themes

The studies in this review explored the physical and mental health of NHS inpatient staff in relation to exposure to high-risk behaviours, the experience of providing nursing care to patients displaying high-risk behaviours (and the impact this can have on therapeutic relationships and staff feelings of confidence in working with high-risk behaviours) and staff access to support following exposure to high-risk behaviours (Appendix B).

Four main themes (negative impacts on health and wellbeing, challenges to the provisions of care and competent working, the impact of the ward climate and perceptions of support, and persistent feelings of fear) and eight subthemes were identified from the articles included in the review (Appendix D). These provide an overview of the current knowledge about NHS mental health inpatient staff experiences of exposure to violence, aggression, self-harm and suicide ideation. Narrative synthesis of the quantitative data is provided in the first instance, and is then contextualised alongside the findings of the qualitative data, supported with participant quotes from the included articles. Table 1 demonstrates which papers contributed to each theme in this review.

Table 1 – Article contributions to themes and subthemes

Main Themes	**Subthemes**	**Article Contribution**
1. Negative impacts on health and wellbeing	A. Poorer physical health related to violence and aggression	Currid (2009); O'Brien, Tariq, Ashraph and Howe (2013); Renwick et al., (2019)
	B. Poorer mental wellbeing related to exposure to high-risk incidents	Beryl, Davies and Völlm (2018); O'Brien et al., (2013); Reininghaus, Craig, Gournay, Hopkinson and Carson (2007); Renwick et al., (2019); Whittington and Wykes (1992); Wykes and Whittington, 1998)
2. Challenges to the provisions of care and competent working	A. Perceived incompetence in working with high-risk behaviours	Beryl et al., (2018); Jeffery and Fuller (2016); Jussab and Murphy (2015); Rouski, Hodge and Tatum (2017)
	B. Feeling emotionally conflicted towards patients	Beryl et al., (2018); Jeffery and Fuller (2016); Jussab and Murphy (2015): Rouski et al., (2017)

3. The impact of the ward climate and perceptions of support	A. Positive experiences of support and helpful ward environments	Beryl at al., (2018); Jeffery and Fuller (2016); Jussab and Murphy (2015); Rouski et al., (2017); Reininghaus et al., (2007); Whittington and Wykes, (1992)
	B. Inadequate support and unhelpful ward environments	Beryl et al., (2018); Currid (2009); Jeffery and Fuller (2016); Jussab and Murphy (2015); Whittington and Wykes, (1992)
4. Persistent feelings of fear	A. Prolonged sense of fear for own safety	Beryl et al., (2018); Jussab and Murphy (2015); Reininghaus et al., (2007)
	B. Ongoing concern for the safety of others	Beryl et al., (2018); Jeffery and Fuller (2016); Reininghaus et al., (2007); Rouski et al., (2017)

1.5.4.1 Theme 1: Negative impacts on health and wellbeing

This theme identifies that exposure to incidents of high-risk behaviours has a number of negative implications for the physical and mental health and wellbeing of staff, including the presence of symptoms of post-traumatic stress disorder.

Poorer physical health related to violence and aggression: Staff exposed to incidents of violence and aggression were found to have significantly poorer physical health than the general population (Renwick et al., 2019), with as many as 41% taking time off sick in the past year as a result of these incidents (O'Brien et al., 2013). This was particularly the case for lower grade staff, such as healthcare assistants, who experienced poorer physical health than their qualified nurse and psychiatry colleagues (Renwick et al., 2019).

The impact of this was obvious to some staff, who described clear symptoms that they were experiencing physical ill effects from the daily demands of managing high-risk behaviours:

Currid, (2009, p. 44): "I get headaches, neck pain…"

Poorer mental wellbeing related to exposure to high-risk incidents: Incidents of violence, aggression, self-harm and suicide ideation all had a negative impact on the mental wellbeing off staff. The experience of being physically assaulted was significantly associated with feelings of psychological distress, symptoms of which included low morale, feeling shaken, fatigue and irritability (O'Brien et al., 2013; Reininghaus et al., 2007; Whittington & Wykes, 1992). Additionally, 17% of staff

displayed clinical symptoms of depression, and 5% met the diagnostic criteria for post-traumatic stress disorder (Wykes & Whittington, 1998).

The long-lasting impact of being involved in incidents of violence and aggression was not always recognised by staff, but could be triggered by coming back in to contact with the patient it concerned:

Beryl, Davies & Völlm, (2018, p. 87): "I was assaulted quite badly…and I didn't realise how much it affected me until the patient came back…I think that was probably one of the lowest [pause] times I've ever felt really".

In contrast, the anticipation of a self-harm incident had a tangible effect on staff who knew it was going to happen, but felt powerless to prevent it:

Beryl et al., (2018, p. 85): "…waiting is draining because you know it's going to happen, you've done as much as you possibly can to prevent it, but you still know it's coming…that's probably the worst bit, more than the actual event itself".

1.5.4.2 Theme 2: Challenges to the provision of care and competent working

This theme demonstrates that staff can feel they lack competence in working with patients who self-harm or display suicide ideation, and that incidents of high-risk behaviours can create conflicting feelings within staff, potentially impacting on patient care and the development of therapeutic relationships.

Perceived incompetence in working with high-risk behaviours: Staff who witnessed incidents of self-harm felt that despite wanting to prevent the incident occurring, they were powerless to do so, and believed that patients would always find a way to harm

themselves (Beryl et al., 2018; Rouski et al., 2017). This also contributed to a sense of responsibility over the event and feelings of failure when staff felt that they had not performed adequately in these situations.

Rouski et al., (2017, p. 13): "But ultimately if you still fail…that particular time you think y'know, I haven't done my job today".

Feelings of failure were also shared by staff who had been exposed to physical violence, who felt that they had let their colleagues down if they had not been able to prevent them getting injured (Jeffery & Fuller, 2016). In addition, failure to adequately utilise therapeutic skills to prevent patient incidents from escalating made staff feel frustrated and upset, as well as making them feel anxious that their competence might be under scrutiny from others:

Jussab and Murphy (2015, p. 291): "…my colleagues were sitting next to me, my team on one side and my assistant psychologist on the other – there was a doctor, SHO [Senior House Officer], the consultant. There's this self-consciousness around how do I deal with this anxiety around behaving professionally, behaving responsibly and not panicking…"

Feeling emotionally conflicted towards patients: Some staff felt conflicted in their feelings towards patients who self-harmed, particularly when they perceived that the incident impacted on their ability to spend equal time with other patients in their care:

Rouski et al., (2017, p. 14): "I think it's difficult to maintain complete professional relationship with that one person who will take up half of your day when you feel like you need to be giving equal time to ten patients".

Additionally, some staff felt that being assaulted, or being threatened with assault, ruptured the boundaries of their therapeutic relationship, leading to feelings of anger and a sense of not wanting to spend time with the patient or engage with them:

Jussab and Murphy (2015, p. 292): "Afterward I was pissed off with her, I did not really want to talk to her. I have a clear recognition of not wanting to contribute to her care".

1.5.4.3 Theme 3: The impact of the ward climate and perceptions of support

This theme suggests that the ward community can contribute to whether staff feel adequately supported following exposure to an incident involving high-risk behaviours, and that at times, the ward environment can feel unhelpful in the management of these experiences.

Positive experiences of support and helpful ward environments: Few studies focused on staff support, but those that did found that having a supportive manager acted as a buffer against psychological distress caused by exposure to high-risk incidents, and in some cases 66% of staff had the opportunity to talk about their feelings with staff at an equal or higher pay grade to themselves within 72 hours of the incident (Reininghaus et al., 2007; Whittington & Wykes, 1992).

Indeed, much importance was placed on having at least one space, either formal or informal, to talk about the impact of the incident. Informal supervision was seen as a way of the staff team looking out for each other, and of showing that this type or work cannot be done in isolation:

Beryl at al., (2018, pp. 87-88): “You can’t do it on your own. There’s no way you could, you need the right people around you”.

Furthermore, the ward community was seen as helpful in finding ways to learn from each other and making use of different people’s strengths and weaknesses to share and build on knowledge and different ways of working:

Beryl et al., (2018, p. 88): “Passing on the skills really as well to the rest of the staff, ‘cause they learn from watching and taking part…”

Rouski et al., (2017, p.14): “…just to learn how different members of the team, different people you work with, how they manage things”.

Inadequate support and unhelpful ward environments: Staff considered that some of the most challenging aspects of their work involved conflicts within the team, particularly when it was felt that some staff did not follow policies and procedures or acted against the consensus of the team (Beryl et al., 2018). Additionally, the support that was offered was inconsistent and the quality varied. Some staff reported that they had not been offered any sort of debrief, and those that had reported feeling unheard and the sense that there was a blurring between the debrief and incident review, making them feel uncared for by the organisation as a whole:

Jussab and Murphy (2015, p. 292): “I was quite surprised actually – you get all the posters about staff will not tolerate violence and you got trained if you’re in doubt about a session and your safety, just do not have the session. And I remember saying to her “I just can’t, I am frightened for my safety, I don’t know how to work with her”. And my supervisor was quite firm and said “but therapeutically that’s really difficult…””.

1.5.4.4 Theme 4: Persistent feelings of fear

This theme identifies how staff develop fears over their own safety following exposure to high-risk incidents, but that they may also become fearful about the safety of others, too.

Prolonged sense of fear for own safety: Reininghaus et al., (2007) found that being physically assaulted was significantly associated with staff perceiving the hospital as more dangerous. Dangerousness and fear of the unknown was highlighted by staff who identified that they were not just fearful at the time of the assault, but also in anticipation of an assault, as they wondered what would happen to them and how they would handle it:

Jussab and Murphy (2015, p. 291): "…as he was shouting I felt quite scared, I was thinking what was going to happen, very aware of where the exits were…He stood up at one point, I was still sitting down, and he was a fairly big chap so he was stood over me and shouting. That was probably the most frightening bit…feeling quite uncertain about what to do, how to handle it".

Ongoing concern for the safety of others: Fear for others was split between staff being concerned and worried about their colleagues, particularly if they felt that they had let them down by not being able to assist or prevent them from being assaulted (Jeffery & Fuller, 2016; Reininghaus et al., 2007) and having fear over patients risking accidental death during episodes of self-harm, particularly if they felt that the patient did not understand the seriousness of their actions:

Rouski et al., (2017, p. 14): "I feel like saying you're all messing, somebody is going to die because we're attending to another young person because you're doing that".

1.5.5 Robustness of the synthesis

The findings from this systematic review demonstrate that exposure to high-risk behaviours can significantly impact on the physical and mental wellbeing of staff. Poorer physical health was particularly a concern for lower grade staff, such as healthcare assistants, and appeared to be related to exposure to incidents involving violence and aggression. Staff also reported low morale, fatigue and irritability, with some meeting the clinical criteria for depression and post-traumatic stress disorder. Despite this, staff highlighted the fact that they did not always recognise the psychological impact exposure to high-risk behaviours had had on them until they found themselves in a repeat situation. Additionally, staff attempting to manage incidents of self-harm and suicide ideation reported feeling powerless in their abilities to stop this from happening, leading to feelings of incompetence and failure. This is supportive of previously mentioned research that demonstrated variance in professional ratings of suicide risk (Paterson et al., 2008), highlighting just how difficult it can be to manage these types of incidents effectively on the wards, and the pressure this can put on staff. Furthermore, staff reported that incidents involving high-risk behaviours can cross a therapeutic boundary, and have a damaging impact on the staff-patient relationship. In turn, a lack of support following these incidents can create an organisational culture where staff feel uncared for. Finally, exposure to high-risk behaviours impacted on the sense of safety staff felt whilst at work, in relation to themselves, their colleagues and the patients with whom they work.

Perhaps one of the limitations of this review was the variance in the quality of the literature, where quality ratings ranged from 0.45 to 0.91. Some of the quality

concerns regarding quantitative studies focused on the lack of inclusion and exclusion criteria for participant selection, making it difficult to account for recruitment bias or bias within the participant sample itself. Additionally, participant characteristics were often not provided, making it difficult to establish which members of staff might be more affected by high-risk incidents, and preventing comparison with other qualitative studies. In general, the main critique of the qualitative studies explored in this review concerned that lack of reflexivity in the account of the data. None of the articles in the review considered how the researcher's experiences or characteristics might have impacted on the data, and as such researcher bias cannot be ruled out from influencing the analysis of the results.

Some might argue that including both quantitative and qualitative data in the review results in an epistemological conflict - can the truth be known and measured directly, or is it understood indirectly through the experience of the people within it? However, including both methodologies allowed for a thorough review of all the relevant literature, and highlighted some key differences between the two which might be useful for future research, and indeed helped to form the aims of this study. For example, all data in this review concerning the impact of violence and aggression on staff mental wellbeing comes from quantitative sources, and also involves contributing factors, such as job security. Therefore, it is possible that it is not the presence of violence and aggression alone that can impact on staff wellbeing, and in fact there may be many others factors which better explain staff experiences. Additionally, the quantitative data is concerned with assessing for symptomology through the use of outcome measures, however, the variation in the longevity of the symptoms described in these articles makes it difficult to conclude whether symptoms

occur briefly after the incident has taken place, or if they are more enduring. Furthermore, the presence or absence of clinical symptoms does not contribute to how staff experience an incident, or the felt impact this has on them. Therefore, it might be helpful to explore staff experience of high-risk behaviours, and the impact this has on them, from a more in-depth or longitudinal perspective.

In addition, little is known about the support staff receive following an incident involving high-risk behaviours, as many of the studies in the review did not focus on this area. Those that did tended to have participants that were qualified members of staff, such as nurses and psychologists, who have regular access to formal supervision. Therefore, there is a scarcity of data exploring support for unqualified members of staff, who typically do not have access to regular supervision and are not trained in reflective practice skills. It might be worth exploring this area further, to identify if the needs of these members of staff differ from their qualified colleagues, and how best to support them in working in difficult and complex environments. Finally, whilst all studies in the review were carried out in NHS mental health inpatient units, there remained a variety of sources from which the data emerged, including differences in ward type and staff group. Therefore, it is difficult to draw conclusions from the existing data as variance may impact on the type of high-risk behaviours experienced by staff, and as previously mentioned, some staff grades may have less support or be better equipped at managing the personal impact of incidents than others.

It remains unclear from this research exactly what impact being exposed to high-risk behaviours has on staff working in NHS acute mental health inpatient units,

particularly as the literature tends to focus on symptomology rather than subjective experience. It is also unknown if staff respond to all high-risk behaviours in the same way, or if reactions to different experiences vary. Additionally, data concerning the quality and availability of support for all staff grades is lacking, making it difficult to know how to support people working in these environments. Considering the sparsity of research concerning NHS inpatient staff experiences of high-risk behaviours, particularly from an exploratory nature, there is a clear need for further research to better understand staff experiences of exposure to these incidents, and what support they receive as a result of this.

1.5.6 Strengths and limitations of the review

This is the first systematic review to explore NHS inpatient staff experiences of exposure to patient violence, aggression, self-harm and suicide ideation, and to also identify whether staff working in these environments receive any post-incident support. Due to the high rates of turnover in these environments, and the risk of burnout staff can face working in these settings, it is important to explore the experiences, views and needs of this group.

There are a limited number of studies exploring NHS inpatient staff experiences of exposure to the aforementioned incidents, and it could be argued that highlighting the sparsity of this research could lead to further studies being conducted in this area. However, one of the inclusion criteria required the article to state the research was carried out within an NHS mental health setting. During the literature search, some articles were excluded as they did not make this clear. Therefore, it is possible that

further literature in this area exists, but was not included in this review due to ambiguity over the setting.

1.6 Part VI: Focus of the present study

1.6.1 Problem statement

It appears that NHS acute mental health inpatient staff can experience negative impacts on their overall health and wellbeing as a result of exposure to episodes of patient violence, aggression, self-harm and suicide ideation, although the research is limited, relies partly on quantitative data collection methods, and at times appears focused on symptomology in staff. Therefore, it remains unclear, particularly from a qualitative stance, exactly what impact being exposed to high-risk behaviours has on staff working on NHS acute mental health inpatient units, and if these experiences vary in response to different risks. It is also unclear whether staff are practically able to access support following exposure to an incident, and if so, of what quality this is, and how helpful it may be in processing the event. It is difficult to understand how the NHS can continue to support its staff members and develop policies designed to assist those confronted with patient incidents without further contribution to this area through academic and research contributions.

1.6.2 Aims and objectives

The literature discussed highlights that staff working in inpatient mental health services are frequently exposed to high-risk behaviours, and that official figures may be an underrepresentation of the frequency of which staff are exposed to such behaviours (NHS Protect, 2016; Pejic, 2005). Research has suggested that in

particular, acute mental health settings experienced a significant rise in high-risk behaviours as compared to other mental health inpatient services (31% increase from 2015/16 - 2016/17, as compared to 5%)(Royal College of Nursing, 2018). Therefore, acute inpatient services have been chosen as recruitment sites in this study, as they may be better placed to comment on these experiences due to the increased presence of these behaviours. The systematic literature review revealed that staff working with high-risk behaviours may show some clinical symptoms of depression, anxiety and PTSD, though there is limited research exploring the impact of these experiences on staff from a qualitative perspective. Additionally, there was emerging evidence to suggest that exposure to some high-risk behaviours left staff feeling incompetent in their work, but it was not clear if this was the case for all high-risk behaviours or all staff groups. Finally, experiences of staff supported were varied, though this data is limited and was often not a key focus of the articles included in the review.

The present study aims to explore NHS acute mental health inpatient staff experiences of exposure to violence, aggression, self-harm and suicide ideation. This will be explored through the following objectives:

1. To explore NHS acute mental health inpatient staff experiences of violence, aggression, self-harm and suicide ideation, and to identify what impact this has on them.
2. To identify how NHS acute mental health inpatient staff currently manage violence, aggression, self-harm and suicide ideation incidents as they arise on the wards.
3. To identify how NHS acute mental health inpatient staff personally manage the impact of an incident after it has occurred.

4. To identify which sources of support staff access and receive, and to understand the impact and quality of this support.

Chapter Two: Method

2.0 Chapter Overview

This chapter will explore the rationale for using qualitative methodology for this study and the chosen method of analysis, with relation to the epistemological stance taken. This chapter will also outline the research procedure for the study, including discussing recruitment, data collection and analysis and ethical considerations.

2.1 Epistemology and justification of methodology

Blaikie (2010) states that researchers are faced with several different challenges when they set out to answer their research questions. Some of these challenges concern selecting the best research strategy for their queries, and may be influenced by certain ontological and epistemological stances. Therefore, it is necessary to review my own philosophical stance in relation to this study in order to provide the reader with transparency.

2.1.1 Ontology

Ontology refers to the "study of being" (Crotty, 1998, p.10) and the "nature of reality" (Creswell, 2013, p. 20). It is important to consider my ontological position, as this identifies how I interpret 'reality', in turn influencing my epistemological position and the research methodology I have chosen. Our ontological assumptions determine how we perceive our relationship between reality and human understandings and practices - whether we believe that reality exists independently of human interpretation, or whether reality cannot be separated from human influence and so understanding will always reflect human perspective (Braun & Clarke, 2013).

It can be helpful to think of these views as laying along a continuum from realism to relativism.

Realism assumes that reality is independent of human ways of understanding and can be accessed using appropriate research strategies and techniques (Braun & Clarke, 2013) and tends to underpin most quantitative research (Robson, 2011). Relativism, on the other hand, proposes that there is no universal truth and that what is 'real' differs across time and context and cannot be separated from human interpretation (Braun & Clarke, 2013), and underpins some qualitative approaches, such as thematic analysis. Mid-way between these two stances sits critical realism, which proposes that reality sits behind a socially influenced knowledge that can be partially accessed; reality exists and can be shared by individuals; however, each person's experience of reality will be influenced by their own subjective knowledge (Braun & Clarke, 2013). I hold a relativist ontological approach to this study. This is because I do not consider there to be an objective truth that is waiting to be discovered, but rather there are differing individual versions of reality that can exist and that can be jointly constructed by the context in which the individual finds themselves, both of which can occur in acute mental health inpatient wards.

2.1.2 Epistemology

Guba (1990) states that epistemology is focused on the nature of knowledge and is concerned with what it is possible to know and how it is possible to know this. Different epistemological stances can be summarised as whether an individual believes reality is discovered through research, or whether it is created through research (Braun & Clarke, 2013). It is important to consider my epistemological

stance, as this will inform my methodology in my attempts to measure reality, and whether I feel I have an impact on my data in any way.

Positivism assumes that a single reality exists and that this reality can be measured and known. Knowledge is discovered through scientific methods of research that allows data to be collected in an unbiased way, free of influence from the researcher (Crotty, 1998). Constructionism, on the other hand, argues that there is no single underlying reality and that all knowledge and reality is dependent on human practice, and is created by the interaction between individuals and their world, and conveyed within a social context (Braun & Clarke, 2013; Crotty, 1998). Contextualism (Henwood & Pidgeon, 1994) falls between these two stances, and argues that whilst there is no single reality, knowledge can still be true in certain contexts. It demonstrates an awareness of the researcher's own positions and ways of understanding reality and suggests that steps can be taken to ensure that these are reflected upon so that the information gathered best reflects the understandings of the individuals being observed or studied, rather than the researchers own ideas (Braun & Clarke, 2013; Crotty, 1998). In this study, I believe that the participants are likely to hold unique and differing understandings of their own reality, influenced by their experiences within their environments. Therefore, I adopt a constructionist epistemology in my approach to this study.

2.1.3 Research paradigm

It is important to understand the paradigm under which research is conducted, as it provides an insight in to how researchers perceive knowledge, apply methodologies in order to obtain knowledge, and view their own relationship with the knowledge

being explored (Guba, 1990). Much like ontology and epistemology, paradigms are considered to sit along a continuum from positivist to interpretivist (Denzin & Lincoln, 2005).

By taking a relativist ontological approach, and a constructionist epistemology, this research finds itself positioned within an interpretivist paradigm (Cohen & Crabtree, 2006). Interpretivism adopts the understanding that realities are socially constructed, and that there can be multiple realities that are constructed through shared meaning (Neufeldt, 2007). Additionally, no separation can be made between the 'knower' and what is 'known', therefore my values are interactive with all aspects of the research process. Finally, reality and truth are context and time dependent, and are therefore changeable across different contexts (Neufeldt, 2007).

Therefore, this research can be seen to follow an interpretivist paradigm as I believe that the experiences of the staff are uniquely situated within the specific inpatient mental health context they find themselves in, and will be further shaped by individual experiences that impact on a shared meaning of the reality of working in this environment. Additionally, this research aims to understand the experience of this particular environment, rather than seeking cause and effect trends, and as such these aims are reflected by the interpretivist paradigm.

2.1.4 Self-Reflexive account

It is important to acknowledge that my beliefs, values and experiences will impact on the research process and the interpretation of participant accounts (Primeau, 2003; Shaw, 2010). Therefore, to promote transparency in the research it is important that I

am able to reflect on this, and how I influence the co-construction of meaning with research participants (Lietz, Langer & Furman, 2006).

I am a white British female, in my late twenties, born in to a working class family. When I left home at 18 to study Psychology at University, I was the first person in my family to have reached this level of academic study. Here, I obtained a upper second-class honours degree. I chose not to complete a masters degree, due to being unable to afford such an expense at the time. Instead, I worked in a variety of different contexts up until commencing training. I worked for two years as a care assistant in a residential care home for people with dementia, for one year as a support worker in a Child and Adolescent Mental Health Service (CAMHS) inpatient mental health hospital, for one year as an assistant psychologist within the same hospital, and for one year as a research assistant psychologist specialising in dementia research. I commenced doctoral training at the age of 26. Much of my clinical experience prior to training was from inpatient mental health settings, and my first placement on the training course was also a mental health inpatient environment. Clinically, I use an integrative approach, favouring compassion focused and systemic theories and models.

My interest in carrying out research with staff working in acute mental health inpatient environments came from my own experiences prior to training. Working in these environments involved 12-hour shifts, attempting to manage and contain highly distressed patients. Following a number of incidents involving myself and different colleagues, I started to noticed there was little space, if any, for staff to reflect on how they were impacted by what they had seen or experienced. Indeed, there was no space

at handover for this to be discussed, and following every incident there was the expectation that you would complete the mandatory paperwork and then carry on with your shift. Perhaps the most difficult time for me was when I experienced a colleague telling the nurse in charge that she was struggling following a physical assault from one of the patients, who responded by saying that she herself had been involved in a similar assault and she was fine, so perhaps my colleague ought to carry on with her work. I felt incredibly conflicted by this, and began to wonder how I could work in an environment designed to be therapeutic and understanding of individual needs, yet so rejecting of staff concerns.

I did not know anyone else working in a similar environment at the time, so decided to see if there was any research on staff experiences of working in these environments. I will admit that I was shocked to discover there was very little, and found myself feeling upset about this. Whilst working in the NHS, I also started to find myself becoming annoyed at the frequent email reminders for staff to take care of their well-being, and the posters in the staff room directing you to occupational health if you felt you needed support and advice. It felt like there was much responsibility on staff to ensure they were not negatively impacted by their environment, but no space to think about what it is like to work in challenging environments on a daily basis. I felt that I wanted to give staff the space and opportunity to share their experiences, and to understand what needs to be done to ensure they are supported effectively to allow them to continue carrying out the difficult work that they do.

When promoting my study, I reflected on how I might be perceived by the staff on the wards. I know that they are busy and pressured, and I recognised not only that I was an outsider coming in to a time limited space (mostly handover meetings), but that I also had the luxury of leaving soon after arriving, rather than spending many more hours in that environment. I attempted to communicate as best as possible that I understood the pressures staff were under, whilst also promoting the importance of the research in allowing them to share their experiences. Overall, I felt positively received by many of the wards I visited, however, I did have a few experiences of feeling like a burden, and felt staff were disinterested in my study, which led to feelings of deflation.

Additionally, I reflected on the differences between working as a psychologist and working as a researcher. I wondered how I might be positioned by staff, as I was a trainee psychologist. Would they perceive me as someone with knowledge and skills in both clinical work and academic study, or would they see me as a student, or protected from the realities of clinical working? At times I found it difficult to maintain a neutral stance, and had to resist the urge to explain that I knew how it felt to be in their position. However, I was mindful that I did not want to impact on how the participants told their stories, and was able to remain boundaried in this respect.

Though I was mindful of my own experiences and assumptions on this topic, and tried to prevent any bias from entering the research process, it is likely that my appraisal of participant interviews will in some way be influenced by my own experiences.

2.2 Methodology

My ontological and epistemological stances inform the research methodology used. Methodologies are strategies that are employed to investigate an area of interest, and will be chosen with the belief that this is the best way to explore what can be known (Guba & Lincoln, 1994; Silverman, 1993). Therefore, knowledge can be discovered in different ways, and this is usually determined by the philosophical paradigm of the researcher (Scotland, 2012). Typically, quantitative methodologies are aligned with a positivist philosophical paradigm, in which knowledge is obtained though empirical measurement of the data and takes a structured approach that assumes the researcher is independent of the data (Krauss, 2005; Neufeldt, 2007). Qualitative methodology, on the other hand, tends to be associated with an interpretivist philosophical paradigm, where the aim is to describe and understand an investigated phenomenon, rather than predict or draw causal relations from the data, and as such the data is not suited to statistical analysis methods (Hudson & Ozanne, 1988; Maxwell, 2012). The aim of this research study was to explore NHS acute mental health inpatient staff experiences of exposure to high-risk behaviours, and what impact this had on them. This is an area where multiple realities might exist, and there is no desire to search for cause and effect implications. Therefore, I felt a qualitative methodology was appropriate for this study, in keeping with my interpretivist philosophical position, as I sought to explore multiple participant realties which are likely to be time and context dependent (Hudson & Ozanne, 1988).

2.2.1 Data collection

There are a number of different methods than can be used to obtain data within a qualitative methodology. Some common approaches of data collection are discussed

here, along with my justification for choosing to use semi-structured interviews to collect my data.

Focus groups provide a context within which a group of participants engage in collective conversations about the area being investigated, where they are able to comment on each other's remarks and challenge ideas and thoughts, guided by the researcher who acts as a moderator (Kitzinger, 2005; Wilkinson, 2004). The use of focus groups were not deemed a suitable method of data collection for this study. Firstly, the study aimed to explore individual experiences in depth, something which cannot be achieved in a focus group setting. Secondly, for successful discussions to occur within focus groups, there needs to be a feeling of safety (Hennink, 2007). Given that people may have different experiences from each other, and are required to work together in a team, it was felt that this might prevent participants from fully disclosing their experiences, or that what was disclosed might impact on colleague relationships, and would therefore inhibit the freedom of expression that would contribute to this method of data collection.

Participants observations (ethnography) are another method of obtaining qualitative data. This involves observing participants as they carry out their activities in order to capture social meaning and directly observe the area being investigated (Brewer, 2000). It was felt this this was not a suitable method of data collection for this study, as it would not have been practical to observe staff members managing incidents of violence, aggression, self-harm and suicide ideation. Additionally, this method of data collection would provide information on how staff members respond during and after

an incident, but would not provide much information on their experience or the personal impact of this, which is one of the aims of the study.

Qualitative methods of data collection can also involve the use of textual data. This involves the collection of data generated from participants in the form of written formats, such as keeping diaries and journals on the area of interest (McKee, 2001). This method of data collection was not deemed suitable for this study. It takes great commitment of time and effort from the participants to gather data in this way, leading to high drop-out rates. This was particularly the concern given the knowledge that staff working in these environments already work long and busy shifts.

Finally, in-depth interviews can be used to gather data using a qualitative methodology. They can be used to gather information about participant experiences, particularly when investigating sensitive topics (Mack, Woodsong, Macqueen, Guest & Namey, 2005; Rubin & Rubin, 1995). In-depth interviews can be structured, where questions are pre-determined and tend not to deviate from the schedule, unstructured, where a schedule of pre-determined questions can be used as a guide, but there is flexibility in the application, leading to longer interview and analysis processes, and semi-structed, where there is the opportunity for flexibility, but a clear set of questions of interest is defined and worked through (McLeod, 2014; Robson, 2011). Semi-structured interviews were deemed a suitable method of data collection for this study, as it allowed participants to flexibly reflect on their experiences whilst still maintaining a structure that might be helpful for guiding interviews, particularly when discussing sensitive topics.

2.2.2 Justification of Thematic Analysis

Just as a number of data collection methods exist for collecting qualitative data, so too are there a number of ways of analysing the data this produces. The method of data collection and analysis is guided by the focus of the research question (Egan, 2002). Different approaches to data analysis will be discussed, and I will provide my justification for using Thematic Analysis in this study.

Grounded Theory (Glaser & Strauss, 1967) takes a systemic approach to data analysis that seeks to conceptualise data to generate concepts and hypotheses about the area being investigated. Whilst this can provide in-depth and rich data description, theories produced might be limited in their generalisability and can lack methodological rigour, as there is a lack of consensus regarding the method (Barbour, 2001; Charmaz, 2006). Grounded theory was not deemed appropriate for this study, as it aims to explore staff experiences of being exposed to high-risk behaviours, rather than develop theories to explain them. In addition, it did not seem probable that sufficient numbers of participants could be reached to meet theoretical saturation (Brown, Stevenson, Troiano & Schneider, 2002) due to the difficulties in recruiting in these contexts.

Interpretive Phenomenological Analysis (IPA)(Smith, 1996) explores how individuals perceive their experiences by recruiting small homogenous samples and generating themes within and across data sets (Smith, Flowers & Larkin, 2009). IPA assumes that you cannot separate participant experiences from the context they are in, and involves interpretation of both participants (regarding meaning making of their experiences) and researchers (interpreting and making sense of the participants'

views)(Hefferon & Gil-Rodriguez, 2011; Smith et al., 2009). As the aim of this research study was to explore and describe participant experiences, rather than to interpret them, it was deemed that thematic analysis would be better suited to this approach than IPA.

Conversation analysis (Psathas, 1995) follows a clearly defined framework and detailed approach to describing patterns and structure of conversation. It explores how interaction occurs through a focus on organisation and turn-taking during conversation (ten Have, 1990). As this study was not focused on how participants interact, it was not deemed a suitable method of analysis.

Thematic Analysis is a process of encoding information that can be used with most, if not all, qualitative methods (Boyatzis, 1998) due to its freedom from theoretical and epistemological approaches (Braun & Clarke, 2006). Thematic Analysis has been regularly used by psychology, though often without being specifically described or stated (Boyatzis, 1998). Whilst Boyatzis (1998) described Thematic Analysis as a tool that can be used across different qualitative methods, Braun and Clarke (2006) argue that Thematic Analysis is a method in itself, concerned with identifying, investigating and reporting patterns within data in relation to specific research questions or ideas. Furthermore, researchers using Thematic Analysis do not require specialist training in the area, and the development of clear guidelines for conducting Thematic Analysis makes it a suitable approach for novice researchers (Braun & Clarke, 2006). Thematic Analysis was considered an appropriate method for this study as it allows data to be analysed meaningfully using a structured process, without needing to subscribe to theoretical or epistemological commitments (Braun &

Clarke, 2006). Additionally, Thematic Analysis allows for inductive or deductive, semantic or latent, approaches to data analysis, further making it appropriate for this study as the researcher is not attempting to fit the data into an existing frame or their own preconceptions, and is only concerned with the explicit meanings of the data provided. This is a useful way of exploring areas that are under-researched or where participants views on the topic are not known (Braun & Clarke, 2006) and as such seems appropriate for this study and meeting the study aims.

2.3 Ethical Considerations

Professional guidance for conducting ethical human research was adhered to (British Psychological Society, 2014).

2.3.1 Informed consent

As this research study involved staff members as participants, obtaining informed consent was relatively straight forward. In order to establish informed consent, participants need to be able to freely make a decision about their participation in research on the basis of adequate information (BPS, 2014). Potential participants were provided with information sheets (Appendix E) which detailed the purpose and aims of the study, what taking part would involve, the type of data that would be collected, as well as how this would be stored and used, how confidentiality and anonymity would be maintained, the right to decline to take part or withdraw from the study, and to make a complaint should they wish to do so. The information sheets were written in plain English, avoiding the use of jargon where possible. Finally, participants were given a minimum of 48 hours between receiving the information sheets and follow-up contact, allowing them appropriate time to decide if they wished

to take part in the study, and providing the opportunity to ask any questions about the study or their involvement (Health Research Authority Guidance, 2017). Consent forms (Appendix F) were signed in my presence by all participants.

2.3.2 Confidentiality and anonymity

Potential participants were informed on the limits of confidentiality, and understood that should they disclose information suggesting that they, or someone else, was at risk of harm, or if a crime had been committed, confidentiality would need to be breached (BPS, 2014). Participants were advised that, as far as possible, the need to break confidentiality in these circumstances would be discussed with them beforehand. Participants were made aware that direct quotations may be used from their interviews in the write up of the study. Therefore, participants were informed that they would be provided with pseudonyms in order to ensure their information and data would not be identifiable. Interviews took place at the recruitment sites in a private room, which again helped to maintain confidentiality and anonymity of those who had chosen to take part.

2.3.3 Data storage

Interviews with participants were audio recorded via Dictaphone, and later transferred to a secure computer system at the University of Essex. Once the interviews had been transcribed and made anonymous, the audio was destroyed. Only I had access to the password protected document where the transcribed interviews were stored. The research data was stored in a password protected document, which only I could access. Participants were aware of data storage procedures, and consented to their data being managed in line with the Data Protection Act (2018).

2.3.4 Right to withdraw

Participants were informed of their right to withdraw from the study without this having an impact on their work (BPS, 2014). This was made explicit in the information sheets and consent forms.

2.3.5 Protection from harm and debriefing

The study was not expected to cause distress to participants, however, due to the nature of the conversations it was possible that some participants might have become upset or angered during the interview process. In order to minimise this, participants were reminded that they could take breaks during the interviews, or to stop it completely if they no longer wished to carry on. Participants were also informed that I would stop the interview if I felt the participant was becoming distressed. Participants were fully debriefed after their interviews (BPS, 2014) and as a routine, contact details for the Samaritans were provided. The potential benefits of taking part in the research must balance out any risks to taking part. It was hoped that the findings of research would help to provide a deeper understanding of the experiences of staff who are exposed to high-risk behaviours and the impact this has on them, as well as understanding the support they received. Providing participants with the opportunity to share their thoughts on this may have provided them with the opportunity to share their experiences and in a way that might help to inform service improvements and NHS policies regarding this context, and may help guide developments that may need to be made as a result of the findings.

2.3.6 Risk

Trust policies and guidelines concerning lone working were adhered to as interviews were conducted alone, however, as interviews were conducted with staff the risk to the researcher was considered to be low. It was possible that I might become upset as a result of the sensitive topics being discussed, and this was monitored through my own use of reflective practice and reflective journals.

2.3.7 Ethical approval

Full NHS ethical approval was received on 1st February 2019 (Appendix G). Local NHS Trust Research and Development approval was gained on 6th February 2019 for one Trust, and 31st May 2019 for another Trust (Appendix H). University of Essex ethics committee granted ethical approval on 30th April 2019 (Appendix I).

2.4 Method

2.4.1 Research design

An exploratory, naturalistic, qualitative methodology was used to explore and understand the impact of exposure to high-risk behaviours on NHS acute mental health inpatient staff, and what support they received following these incidents.

2.4.2 Service context

Participants were recruited from two NHS Trusts providing mental health care for adults. The recruitment sites identified provided acute mental health inpatient care for people detained under the Mental Health Act (1983, 2007), or who were informally admitted. Adults admitted to these units experience significant mental health

difficulties, and are deemed to pose a serious risk of harm to themselves or others which cannot be adequately managed in the community.

Mental health beds in England have fallen 73%, from around 67,000 to 18,400, since 1987/1988 (Wyatt, Aldridge, Callaghan, Dyke & Moulin, 2019). Therefore, in order to protect the anonymity of participants in this study, specific service information has not been provided.

2.4.3 Participants and sampling method

Qualitative research taking an interpretivist approach typically uses purposive sampling to identify and select cases that make the most effective use of limited resources (Patton, 2002). This allow me to select participants that are knowledgeable or experienced about a particular area of interest (Creswell & Plano Clark, 2011). The type of recruitment used in this study used a combination of criterion and emergent sampling (Patton, 2002).

Inclusion and exclusion criteria were established between myself and my academic supervisor. Due to the limited research in this area, participants were not restricted on job role, and so anyone employed within an adult acute mental health inpatient setting by the recruitment sites were able to participate. Inclusion criteria required participants to be aged 18 and over, employed by the NHS to work in the recruitment sites specified for a period of at least six months, and subjectively feel that they can comment on exposure to high-risk behaviours that occurred whilst they were at work. Exclusion criteria meant that staff who were not directly employed by the NHS, such

as agency staff, could not participate in the study. This is because support for agency staff may vary in comparison to those employed directly by the Trust.

There is some ambiguity concerning the recommended sample size for qualitative studies. It is argued that the best way to ensure qualitative research demonstrates validity is to reach data saturation (Mason, 2010), however, the idea of data saturation is challenging and may never be reached (Wray, Markovic & Manderson, 2007). It is suggested that doctoral projects using Thematic Analysis aim to recruit between 10 and 20 participants (Braun & Clarke, 2013).

Twenty members of staff employed by the NHS Trusts identified as recruitment sites expressed an interest in taking part in the study. Of these individuals, three did not attend the arranged interview dates, and seven did not respond to emails attempting to organise an interview. All ten did not respond to follow-up email attempts, and so were considered to no longer be interested in taking part in the study. Therefore, ten remaining participants were recruited to the study. While this sample size is at the lower end of the suggested range (Braun & Clarke, 2013), data saturation appeared to be reached during the analysis stage. Part of the process of Thematic Analysis involves immersion in the data, where I continuously reviewed and checked the codes, themes and subthemes within and across data sets (Braun & Clarke, 2006). This step ensured that I had fully explored the data, and that I was confident that data saturation had been reached. Data saturation was indicated following immersion in the data by no new information coming to light, no further discoveries of new information that added to the topic of investigation, and repetition and confirmation

of themes within the data (Mason, 2010)(see Appendix J for participant contributions to themes).

2.4.4 Data collection

An interview schedule was developed for the purpose of this study and data was collected using semi-structured interviews. A guided interview approach to in-depth interviewing was used to ensure a full understanding of the participant's point of view was obtained, and allowed me to probe and explore further the comments the participant had made (Berry, 1999).

Consultation with members of staff currently working in NHS acute mental health inpatient services (clinical psychologists and registered nurses) provided anecdotal insight in to areas that might be worthy of exploration, and formed the first draft of the interview schedule. Further consultation with research supervisors and guidance for developing and conducting the interview (McNamara, 1999) led to the final schedule that was used in this study (Appendix K). Key topics for exploration within the interview included how incidents of high-risk behaviours are currently managed on the wards, the impact that exposure of high-risk behaviours has on staff, how staff personally manage their wellbeing following an incident, and what support staff receive following exposure to an incident. Participants were also given the opportunity to comment on any other aspect of exposure to high-risk behaviours and support at the end of the interview.

2.5 Research Procedure

The research procedure involved four unique stages: research promotion, recruitment, data collection and data analysis.

2.5.1 Stage one: research promotion

I attended a number of handover and business meetings across different wards within the Trusts to promote the study to potential participants. These are predominantly attended by nursing staff and ward managers. In addition, I spent time liaising with other members of staff on the ward outside of the scheduled meetings. It was hoped that my presence on the ward would help staff to make more of a connection to the study, as they would be aware of who I was. Finally, some wards distributed an email to the ward teams that included the participant information sheet and my contact details, to allow a further way for staff to show their interest in the study. During meetings and discussions with the staff team an overview of the study was provided, information sheets were handed out, and it was made clear that participation was voluntary. The importance of confidentiality was also discussed, as some staff were worried that it would be possible to identify them if their quotes were used in the write up.

2.5.2 Stage two: recruitment

Participants who expressed an interest in taking part in the study did so either by giving me their name and email address, or by emailing me directly. Once screened for eligibility, I contacted staff to arrange suitable times to meet to carry out the interview. During this time, staff were reminded that their participation was voluntary, and they were free to withdraw from the study at any time.

2.5.3 Stage three: data collection

An agreed date and time was arranged between the participant and myself. I then booked a private room at the recruitment site to ensure privacy and maintain confidentiality. Prior to the interview, participants were given the opportunity to ask questions and I ensured that participants understood what taking part would involve. Informed consent was gathered from all participants prior to the interview commencing (Appendix F).

Interviews were expected to last between 45 and 75 minutes, however, it was understood that this was likely to vary dependent upon participation elaboration on their answers. In actuality, interviews lasted between 22 and 46 minutes, with a mean length of 33 minutes. Demographic information was obtained at the start of the interview concerning gender, job role and length of experience in mental health inpatient settings (Appendix L) and then followed the interview schedule as documented earlier (Appendix K). All interviews were audio recorded through the use of a Dictaphone.

2.5.4 Stage four: data analysis

All interviews were transcribed and analysed using Thematic Analysis (Braun & Clarke, 2006). Interviews were manually transcribed by myself, using Microsoft Word and Windows Media Player. Overall, each interview was listened to and checked on three occasions – for initial transcription, to ensure the accuracy of the initial transcription and to make necessary editions, and to ensure the final

transcription matched the interview to which is was associated. Coding examples can be seen in Appendix M.

2.6 Data Analysis

Following each interview, reflective journals were used to detail my thoughts and feelings about the process (Appendix N). The use of reflective journals helps to promote transparency and the quality of the research, as it allows the reader to draw their own conclusions as to the extent of researcher bias in the analysis.

2.6.1 Data transcription

It is acknowledged that a written transcript will never produce an entirely verbatim account of the interview, due to the ongoing analytical and interpretive decisions that are made by the researcher, including deciding what to include and what to exclude from the transcript (McLellan, MacQueen & Neidig, 2003). Despite this, it is important that guidelines are followed in order to ensure the transcript provides the best representation of the data. Using these guidelines, I chose to include participant pauses, sighs and laughter in the transcript, and substituted identifying information, such as names and places. Repeated checking of the data allowed me to become familiar with, and immersed in, the data (Braun & Clarke, 2006).

2.6.2 Thematic Analysis

Thematic Analysis can take an inductive or deductive approach to coding, and it depends on the philosophical paradigm of the researcher as to which one will be best suited to answer the research questions of interest (Braun & Clarke, 2006). For this study, an inductive approach was utilised, as the intention was not to fit the data in to

an existing frame but rather to allow themes to emerge from the data, attempting to mitigate against the potential influence that preconceived ideas I might have on the analysis. However, it is acknowledged that it is not possible to fully separate my experiences, beliefs and ideas from the data, and analysis by another researcher may reveal different results (Thomas, 2003).

Additionally, themes in Thematic Analysis can be constructed at either a semantic or latent level (Braun & Clarke, 2006). For this study, I chose to construct themes at a semantic level, based on explicit accounts of what participants said, rather than interpreting deeper meaning in their language. I felt that, given the scarcity of research in this area, it was important to represent participant views as closely as possible to how they were described, though acknowledged this might have resulted in the loss of some deeper level findings or nuances in the data. Nvivo software was used to assist with the coding of the data, and the analysis itself followed Thematic Analysis guidelines by Braun and Clarke (2006)(Appendix O).

2.6.3 Quality assurance

One of the critiques of qualitative data concerns the difficulties in establishing its trustworthiness, particularly when contrasted with ideas such as reliability and validity that are used to assess the quality of quantitative research (Cutcliffe & McKenna, 1999; Shenton, 2004). Despite this, there are techniques available to enhance the trustworthiness of qualitative data that address concepts of credibility, transferability, dependability and confirmability (Lincoln & Guba, 1985) which have been used in this study.

Credibility ensures that the reported findings of the study are an accurate interpretation of participant experiences as detailed in their interviews (Lincoln & Guba, 1985). The credibility of this study was enhanced by being immersed in the data, transcribing interviews by hand, and listening to the recordings on a number of occasions in order to check for accuracy and to become familiar with the data. Morse (1994) suggests that member checking of the data can be a further useful way of establishing credibility. I had intended to use this method in this study, however, due to time constraints and participant pressures this step was not able to be completed.

The transferability of the data is concerned with the extent to which it can be generalised to other settings and contexts. However, the context within which qualitative data is gathered must be appreciated (Shenton, 2004), and transferring findings from one context to another becomes the responsibility of the person who wishes to do so (Lincoln & Guba, 1985). In order to promote transferability of the data, the research setting and methodology used in this study are accurately described, so generalisations can be made by the reader if required (Shenton, 2004).

Dependability is concerned with whether the researcher has accurately and carefully analysed, recorded and presented the data (Lincoln & Guba, 1985). To enhance the dependability of this study, the research design and procedures are described in detail, data collection and analysis was carried out systematically, and interpretations of the data are supported with verbatim quotes from the participants (Lewis & Ritchie, 2003).

Finally, confirmability reflects the objectivity of the data and posits that the presented findings are not significantly influenced by the beliefs, experiences and bias of the researcher (Lincoln & Guba, 1985). By including a reflective account I have outlined my experiences in this area, and the use of reflective journals allowed me to monitor my own responses to participant interviews during the research process. The reader can therefore make judgements about the confirmability of the data with this knowledge in mind.

2.6.4 Dissemination

Following study completion, a summary of the findings will be circulated to participants via email who indicated that they were interested in receiving these. Additionally, summary reports of the entire study will be circulated to the staff teams via email at both Trusts. This information will be sent to the contact persons who have been involved in wider liaising during the study, which includes Ward Managers and Clinical Psychologists. They will be asked to send on this information to their staff teams. Finally, the findings of this paper will be written up for publication in a suitable journal, such as the Journal of Psychiatric and Mental Health Nursing.

Chapter Three: Findings

3.0 Chapter Overview

This chapter presents the results of the study. Participant demographics are provided as far as possible, whilst still maintaining anonymity, and the themes and subthemes generated from the data are discussed. Verbatim quotes from participants are used to further support the interpretation of the findings and to provide context to participant experiences. Pseudonyms were allocated to the participants by the researcher.

3.1 Participants demographics

Table 1 outlines the job roles of the participants and details their allocated pseudonyms, chosen by the researcher. Ethnicity has not been provided in this table in order to preserve anonymity, however, participants described themselves as Black African, Black British Caribbean, Indian, Northern European, White British, British Pakistani, Asian, Mixed British Asian and Pakistani, and ranged from 24 – 56 in age. Seven participants identified as female, and used she/her pronouns, and three participants identified as male, and used he/him pronouns. Staff had worked in inpatient services for a range of 1 – 10 years (with a mean of 4.6 years) and had been employed in their current roles for a range of 1 – 7 years (with a mean of 1.7 years).

Table 1 – Pseudonyms and job role of participants

Participant Number	**Gender**	**Allocated Pseudonym**	**Job Role**	**Ward Type**
One	Female	Jane	Nursing Associate	Male Only
Two	Female	Karris	Occupational Therapist	Acute
Three	Female	Allie	Ward Manager	Male Only
Four	Female	Isobel	Nursing Associate	Older Adult
Five	Male	Will	Occupational Therapist	Acute
Six	Male	Pete	Doctor in Psychiatry	Male Only
Seven	Female	Sue	Assistant Psychologist	Female Only
Eight	Male	Dan	Staff Nurse	PICU
Nine	Female	Georgia	Doctor in Psychiatry	PICU
Ten	Female	Lauren	Assistant Psychologist	Acute

PICU = Psychiatric Intensive Care Unit

3.2 Themes and Subthemes

Three themes with ten subthemes were derived from the data using thematic analysis (Braun & Clarke, 2006). Themes included the direct impact of the incidents on participants, participants attempts to manage the impact of the incidents and the systems that are currently in place for practical incident management, including staff support. An overview of these themes and subthemes is provided in *Table 2*. Participant contributions to each theme and subtheme can be seen in Appendix J.

Table 2 – Themes and Subthemes derived from the data

Theme	**Subthemes**
Direct Impact of Incidents	Heightened threat system
	Feeling emotionally overwhelmed
	What do I do to help you? The struggle with self-harm
	The worst-case scenario
	You're just fighting an uphill battle
Attempts to Manage Impact	Defending against the impact of incidents
	Just get on with it
	You have to remember they're unwell
Current Systems for Managing	Practical incident management
	Support systems: Good, Bad and Absent

3.2.1 Theme One: Direct Impact of Incidents

This theme describes the direct impact that exposure to incidents of violence, aggression, self-harm and suicide ideation has on staff members. The first subtheme,

heightened threat system, captures the biological and psychological impact that these incidents have on staff, and is characterised by feelings of being on guard whilst on shift. The second subtheme, *feeling emotionally overwhelmed,* describes the emotional impact that incidents have on staff and to related episodes of sickness and low morale. The third subtheme, *what do I do to help you? The struggle with self-harm,* explores the impact exposure to these incidents have on staff feelings of being able to carry out their jobs to a high standard, as well as feelings of failure and incompetence in relation to certain incidents. The fourth subtheme, *the worst-case scenario,* identifies the long-lasting psychological impact incidents have on staff wellbeing, and how exposure to small incidents can lead to fear of more serious incidents. The fifth and final theme, *you're just fighting an uphill battle*, summarises the real impact that repeated exposure to these incidents have on staff in relation to their attitude towards the work they are employed to carry out, as well as feelings of demotivation, failure and hopelessness in response to repeated failures to support patients.

3.2.1.1 Heightened threat system

Staff described feelings of wariness towards patients who had displayed incidents of violence and aggression. Whilst some of these incidents had been directed at the staff member in question, other incidents may have been witnessed by the staff member, or the staff member may just have been aware of the patient having a documented history of displaying violent and aggressive behaviour. Despite this, staff members still described feeling on edge around certain patients, suggesting that the staff members' biological threat system may be overactive whilst on shift.

Karris (Occupational Therapist): "…throughout the day I was just a bit wary and like looking over my back a lot and if I would come out of my office I'd wait to see where she is first. Erm, and if for example she's coming down the corridor I would probably just wait for her to just walk past and then I would go, because I knew that day she was just lashing out at everyone, erm. So yeah, it wasn't the best environment to work in 'cause you're just very on edge in scenarios like that."

Allie (Ward Manager): "it's a scary-especially because you don't know. You don't know what they're capable of, you don't know their history. Erm, if you do know the history it's still quite scary because you think "he might do it this time" or whatever."

Will (Occupational Therapist): "I remember one particular time when I was put on the floor by a female patient, who the week before had tore a muscle in my arm…so I became slightly wary of her on the ward…and I'm still wary of this woman. Every time I see this woman I still sort-I can feel myself going slightly to one side of her."

This heightened sense of threat was seen across staff who had witnessed or heard about incidents of violence and those who had been personally involved in an incident, and on some occasions on multiple incidents with the same patient. This culminated in a feeling of dread for the staff, something which later impacted on their physical and psychological wellbeing due to being unable to sleep following incidents of violence and aggression, and on their therapeutic relationships with patients.

Lauren (Assistant Psychologist): "I was just dreading going on there and seeing like the carnage."

Isobel (Nursing Associate): "It was incident which I was very stressed about and, erm, it affect me quite-quite a lot. For a few days I couldn't even sleep properly."

Will (Occupational Therapist): "It does affect my relationship with her. Just slightly. Erm, and what I tend to do, I tend to sort of, erm, try a little bit more with

people like that. ‘Cause I know the effect so I try and, you know what I mean? I try and balance my bias if you know what I mean? But there’s not that relaxed, erm, relationship and attitude that I think would be therapeutically better.”

Typically, when under threat an individual will respond with a fight, flight or freeze response. However, staff in acute inpatient mental health units are unable to respond in these ways, despite feeling a sense of threat or dread at the possibility of being involved in an incident of violence or aggression. Therefore, the sense of wariness towards the patient, and the subsequent damage to the therapeutic relationship, may be the result of staff attempting to subconsciously distance themselves from a threatening situation and offer some self-protection. Furthermore, gender bias towards threat was also apparent in interviews with female staff who described interactions with male patients who were, or had a history of, displaying violent or aggressive behaviour. One participant directly named gender as being a threat issue, and another identified feeling more intimidated around male patients. The issue of gender was not mentioned by male members of staff.

Georgia (Doctor in Psychiatry): “Obviously there’s a gender component to it as well, you know. You do feel a little bit under threat because you’re of a different gender.”

Allie (Ward Manager): “Yeah, and for males I always find it quite, erm, intimidating if like they’re very near me, or they’re standing about me or if I’m sitting and they’re standing. It does make you feel quite intimidated.”

3.2.1.2 Feeling emotionally overwhelmed

Staff talking about incidents of self-harm and suicide ideation described feelings of being under considerable pressure and strain, and that there had been times both at

work and at home where these feelings could no longer be contained and were outwardly expressed in the form of crying. Attached to these outward expressions of emotion were feelings of shame and embarrassment, suggesting that staff felt this was not an appropriate reaction to the difficult incidents they find themselves having to manage on a regular basis. This was even the case for staff who described a period of completed suicides within quick succession of each other, at one time mounting to four suicides in three weeks.

Will (Occupational Therapist): "I said-basically to my manager, I'm gonna go off sick 'cause of the stress levels. I can't cope. I'm crying. I was coming in to work and finding myself crying and having to find a room. I'm going in the canteen over there and crying my eyes out…"

Lauren (Assistant Psychologist): "Obviously she completely dysregulated at me and was like 'I'm going to kill myself. I can't believe you're leaving me alone. This is what happened to all my friends who were admitted, and they've ended up like actually killing themselves'. So I was sitting there like 'I already can't take this', and unfortunately-I'm actually embarrassed about it, I started to cry in front of her, and I had-I didn't cry, I just had tears in my eyes and I couldn't control them coming down. So I had to stop the session and be like 'you need to give me an hour', and I was just completely-I had to go in the toilet and have a complete and absolute breakdown."

Despite staff beginning to talk about the emotional impact of exposure to incidents of self-harm and suicide ideation in their interviews, it seemed there was little room for reflection on this, and the topic would quickly move on despite researcher attempts to explore this further. This directly reflected a conflict staff were facing in addressing their emotions on the wards. In some interviews there was evidence that staff felt that outward expressions of emotion should be expressed and communicated, however, these were often embedded in comments to the contrary which suggested doing so

would be unprofessional. This was particularly the case for Will, who would switch between the need to hold in your emotions and remain professional whilst at work, but who also saw the value in feeling the impact of the severity of a completed suicide on the staff that had worked closely with the patient. Interestingly, Will was also more at ease when this emotional expression came from other staff members.

Will (Occupational Therapist): "And we went to this debrief and two of the nurses were sobbing. The new nurses. And I said, sort of as my little bit, I said 'you know what, it's good that you're crying'. I said 'this is the first time-I've been here in almost ten years', I said 'we have these debriefs, and these debriefs are for people crying. That's why we have them. And yet I've never seen anyone cry. Ever. Until today'. I said, 'so you crying-', I said 'that is a good thing. You're being honest with your emotions rather than holding them back'."

The overwhelming impact of working both with incidents of violence and aggression, and self-harm and suicide ideation, was described by staff as having a negative effect on staff morale, which they also related to increased sickness levels among staff. One staff member described having to 'beg' members of staff to come in to work, attempting to reassure them that things would be 'okay', indicating that the impact reaches across all levels of the staff team and adds increased pressure to their work, not just those who may have been directly involved in an incident.

Allie (Ward Manager): "I think you definitely get higher sickness levels. You definitely get the morale just go a little bit when you've got a couple of people-one or two people that are showing that kind of aggression. Erm, yeah. So that's a bit difficult, erm, and it's hard to manage a team where you're constantly trying to beg someone to go-'it's gonna be okay, please just come to work, we're gonna move him', or, you know."

This view was shared by Will, who pointed out that it is not just the presence of high-risk behaviours on the wards that contribute to stress, low morale and sickness levels, but the need to think about and manage the potential for these risks occurring, and generally working in a mental health inpatient environment that can contribute to these feelings. This culminated in a warning about what life is like when you work in a NHS mental health inpatient environment, and further serves to summarise the stress and pressure these staff members are under on a day to day basis.

Will (Occupational Therapist): "And you get low morale. It affects morale and it also affects, erm, sickness. People just go off sick all the time. I mean all the time. People are just off sick with the stress. Erm, and this isn't necessarily suicide, this is day to day work. You know, it's like, yeah, yeah. Don't come in to work in the NHS if you want an easy life, honestly."

Jane, Isobel, Pete and Sue did not describe feeling emotionally overwhelmed by the impact of self-harm and suicide ideation incidents. For Jane and Isobel, both Nursing Associates, this appeared to be because they had not been directly involved an incident regarding these risk behaviours. For both, incidents of violence and aggression were more likely on their wards (Male and Older Adult) than self-harm and suicide ideation. Similarly, both Pete (Doctor In Psychiatry) and Sue (Assistant Psychologist) had not been directly involved in incidents of self-harm and suicide ideation, however, acknowledged that these incidents did happen on their wards. It is possible that their roles allow them some distance from the direct impact of these incidents, as they are less likely to be involved in the management of these high-risk behaviours as they happen than their nursing colleagues.

3.2.1.3 What do I do to help you? The struggle with self-harm

Throughout the interviews with staff there was a clear split in the narrative between incidents and how to manage them. Generally, it was felt that incidents of violence and aggression were managed well, and there was a clear plan for these incidents,

whereas incidents of self-harm and suicide ideation posed a much trickier problem – one which staff seemed to feel more unsure of managing, and found more difficult to understand the triggers for than for incidents of violence and aggression.

Georgia (Doctor in Psychiatry): "I think it's quite tiring for them because they're more psyched up for aggression. You know, their modality is aggression, we can deal with aggression easier. It's easier, we can just put them in seclusion, we can medicate them, we can wait, the psychotic episode will end."

Allie (Ward Manager): "Like, he wasn't aggressive towards me, but he was just trying to harm himself. Was just really fixed on harming himself. Erm, that was quite hard. I find that quite difficult. I'm not very good at that. De-escalation, violence and aggression, I got that. But that I'm just like 'what do I do to help you?'."

This generally led to feelings of failure and incompetence among the staff team. It was difficult for many members of staff to understand what they needed to do to support somebody who was attempting to self-harm, which impacted on their ability to manage the patient during their period of distress. Despite working in a mental health inpatient hospital, where incidents of self-harm and suicide ideation are likely to occur, it seemed that staff lacked confidence in emotionally and practically supporting patients with this.

Lauren (Assistant Psychologist): "Um, 'cause on the ward this year two incidences have occurred where people have killed themselves…and I can't do anything about it, and it's too much. And I thought 'it's gonna happen again now', and it's like 'no'. I felt I wasn't fit at that moment in time to be doing anything for anyone."

Allie (Ward Manager): "It made me feel really sad that this person's in hospital, he's under my care, and he felt like he needed to do that…so I kind of felt like a bit of failure."

Georgia was able to summarise the difference between nursing a patient who was expressing violent and aggressive behaviour, versus someone expressing self-harm and suicide ideation. Again, this further supported the idea that there might be a deficit in the training provided to staff working in NHS inpatient mental health services, and may highlight a need for ongoing or more thorough and in-depth education in this area, both for the benefit of the staff and the patients they work with.

Georgia (Doctor in Psychiatry): "I think you have to be so much more psychologically minded-containing, erm, you know? Constantly providing hope, you know? Encouraging-even though they're probably thinking 'oh my god, this is never gonna change', you know, they probably felt quite desperate at that time. But maybe when the patients are aggressive-some of it is actually about basic nursing needs isn't it? Feeding the patient, helping them, you know? Nursing them in a kind of more direct, general nursing kind of way. And that might feel a bit more comfortable to them."

Neither Karris or Will (Occupational Therapists) commented on practically supporting patients following an incident of self-harm or suicide ideation. It is probable that this is because they are less likely to be directly involved in one of these incidents than their nursing or medically trained colleagues, and so incident management may be less of a concern. Despite this, they both contributed to other themes relating to the impact of these high-risk behaviours on their emotional state.

3.2.1.4 The worst-case scenario

A need for ongoing or further training and education in relation to the management of patients who self-harm and experience suicide ideation was also indicated in interviews with staff who were not often exposed to these incidents. As such, they described this having a much more significant impact on them than incidents they dealt with on a day to day basis.

Dan (Staff Nurse): "…and the worst thing is-like I said about the aggression, we deal with it on a daily basis so it's not something that affects me personally. But the self-harm and the suicide attempt is something that will stay because we don't deal with that kind of stuff on the ward. We've never had somebody cut their wrist on our ward."

The shock of witnessing an incident of self-harm for the first time was described by Dan as something that triggered anxiety among the whole staff team. There was a sense of people reflecting on how the incident could have been significantly worse, a true reality for staff working in these environments. This led staff to worry about the 'what ifs' surrounding the incident, and the impact a more serious incident could have on both staff and patients. It highlights the strain staff can feel in trying to keep patients safe on the wards, and the importance of not underestimating the impact of the seemingly less significant incidents.

Dan (Staff Nurse): "I don't think of the situation as it was, I think of the worst-case scenario. If he had died. If he had cut himself in his room and then left it to bleed to death rather than come to us for help. Even amongst staff we talk about it, we said it could have gone much, much worse. He could have cut himself and obviously bleed to death rather than come to us. It's better he came to us rather than us finding him in that state. Or it could have been a very, very, very bad day for everyone."

Worrying about how an incident can quickly escalate, or how it could have been much worse than it was, was also shared by a member of staff who was directly involved in an incident of aggression. Whilst on the whole she described the incident as being relatively low key in the grand scheme of what could happen on the wards, she raised a valid point about not underestimating the impact of any incident, no matter how apparently small, on an individual. There was a difference here between worst-case scenario for self-harm and suicide attempts, and violence and aggression. Staff were initially worried about the safety of the patient in cases of self-harm, and then about the implications for the staff team, should things go wrong, whereas in cases of violence and aggression the worry was directly related to the staff member's sense of safety whilst at work.

Jane (Nursing Associate): "Erm, it might just be the fact that it was a drink that got poured on me, but it was the fact that I wasn't expecting it. And I said, 'oh my god. If it was very hot this might have scarred my face or something', you know? That was frightening."

Again, both Karris and Will (Occupational Therapists) did not report fearing incidents escalating to the worst-case scenario. This could be reflective of their job-role being somewhat distanced from direct incidents of high-risk behaviours, as well as engaging patients in a different way to their nursing colleagues, so this may not have been a key concern for them.

3.2.1.5 You're just fighting an uphill battle

The reality of working in a high stress, high pressure environment appears to take its toll on staff both personally and professionally. There was a sense staff had come to a realisation that the motivation and drive they had for their work when they started the

job was not the same as it was now that they had been in it for a while. The reason for this was cited as exhaustion and a sense of pushing back against something that was working against you or bringing you down. These feelings of demotivation were also tied in with a sense of sadness for staff, which highlights the conflicts they face in trying to do a job that is aimed at helping people, versus a need for self-protection and self-management.

Lauren (Assistant Psychologist): "…you're just fighting an uphill battle and it can completely just tire you out and exhaust you, and you just lose that drive I had at the beginning-at the start of this job, like 'oh maybe this. Go, go, go, go'. And then it's just reducing over time, like 'maybe don't go. Just accept it how it is, I can't do much and it's starting to affect me now, so I just need to pull back' kind of thing. Which is a shame for them then, 'cause I don't try as much because I'm like-yeah, it's kind of demotivating actually.".

Lauren's demotivation also highlighted an important consequence for the patients she works with, and her colleagues, a feeling of pulling back from her work and not trying as much as she used to. While this helps to protect Lauren against further burn-out and exhaustion, it increases the potential risk that patients do not have their needs met, and may further increase the workload of the rest of her colleagues. This potential increase in workload may push an already stretched and stressed staff team further in to burnout and exhaustion, and may cause others too to take a step back from their roles. This has the potential to create a cycle of increased stress and withdrawal that can be hard to break out from.

Jane (Nursing Associate): "…they might not react but their attitude to work might be different. You see? So they might not-for example, if they were doing like ten

tasks complete, they might decide to do like six or seven…I'm not saying that's what I'm doing, but that might happen as well.".

In addition, staff also described how repeated failed attempts to adequately support patients made them feel defeated and hopeless, further contributing to feelings of demotivation and withdrawal from their work. It appeared that this culmination of perceived failures to help patients was difficult for staff to manage personally and professionally.

Lauren (Assistant Psychologist): "Unfortunately you have to like hit that point which you're like 'okay, everything I'm doing is not working', and like-I just started to avoid going on the ward even. I would sit in the library and do work, which is not my role.".

3.2.2 Theme Two: Attempts to Manage Impact

This theme describes staff members' attempts to manage the impact of exposure to incidents of violence, aggression, self-harm and suicide ideation. The first subtheme, *defending against the impact of incidents,* looks at how staff attempt to monitor their own wellbeing and mitigate against the effects of the incidents they have experienced. The second subtheme, *just get on with it,* describes the psychological processes that come in to play to protect individual staff members, and whole staff teams, against the difficult incidents they are exposed to and are expected to work with. Finally, the third subtheme, *you have to remember they're unwell,* identifies a staff need to explain away the incidents they are exposed to, and highlights the search for an explanation for the behaviour to mitigate against the difficult feelings they might experience when working in this environment.

3.2.2.1 Defending against the impact of incidents

Staff described limited attempts to manage their own wellbeing following exposure to incidents of risk behaviours whilst on shift, and there was a divide between those who identified using well documented positive coping strategies, and those who used strategies that may not be beneficial in the long term. Exercise is well documented as having a positive impact on an individual's wellbeing, and was the strategy of choice for staff who identified a need to look after their own health as a result of their experiences at work.

Karris (Occupational Therapist): "Erm, well I go to the gym every day. Monday to Friday. So I did that, and that was really helpful that day. Erm, I do find the gym often does help a lot when I've had like difficult days at work".

Lauren (Assistant Psychologist): "…these things that I teach them to do I wasn't even doing myself. Good, hypocrite over there. Yeah, so just doing those things. Just the simplest of things like yeah please continue exercising because you really do need to do that".

Often staff found it difficult to identify what they did to manage their own wellbeing following exposure to an incident at work. There was a need for staff to shut off or distract themselves from the incident, and some members of staff attempted to draw a clear line between work and home life. This shutting off suggests that staff are not able to process the incidents that they are exposed to, something which is known to contribute to increased stress, burnout and potential trauma related responses in the long-term. Furthermore, staff attempts at shutting off and distraction ranged from escaping reality by watching TV and listening to music, up to excessive alcohol consumption.

Dan (Staff Nurse): "Usually when I'm at work I don't think about home. When I'm at home I don't think about work. Once I've left that place it's over".

Will (Occupational Therapist): "I go home and I've cried my eyes out like. At home. Erm, I go straight to the pub, you know what I mean? Go straight to the pub. Go to get drunk".

Whilst staff appeared to find it difficult to identify ways of coping generally, Lauren reflected on the fact that over time she had learnt the importance of looking after her own wellbeing. She admitted that it had taken her some time to identify how valuable this was, though spoke encouragingly about how she was now implementing these steps to help her manage her working day. However, Lauren was the exception here, rather than the rule.

Lauren (Assistant Psychologist): "…keeping a work life balance is absolutely vital. Leaving on time, vital. All these small things make a massive difference. Which I learnt a bit late but-learned them".

3.2.2.2 Just get on with it

Staff may have had difficulty identifying the impact incidents have on them, and how they go on to manage these, due to working in an environment where denial of the impact and desensitisation to incidents is commonplace. It felt as though this need to defend against being exposed to risk behaviours arose as a direct result of witnessing them on a frequent basis and was viewed by many as being an expected part of their job.

Karris (Occupational Therapist): “it’s probably not a good thing but you kind of become immune to it after a while-self-harm, like, hearing about really horrible abuse. Erm, just having to get on with it after being verbally abused by a patient every day. Erm, you kind of just become immune to it”.

Will (Occupational Therapist): “before you work in an environment like this where people kill themselves regularly, you sort of-like suicide is a shock isn’t it? It’s always a shock, but you get used to it quite quickly. And I got used to it quite quickly. After a few months someone said ‘blah blah is dead’, and you sort of go ‘oh’. It’s an initial shock and then five minutes later you’ve forgotten about it”.

Dan (Staff Nurse): “For me it’s like I said, it’s just I deal with it, I’m used to it, tomorrow’s another day. If it happens, I’ll deal with it again…If I see an incident happen on the ward it’s just part of the job. It’s happened too many times and now you look at it as if it’s just anything-another day”.

The idea that exposure to incidents of violence, aggression, self-harm and suicide ideation is ‘just part of the job’ is one that in ingrained among the staff team, and contributes to the culture of being desensitised and immune to the effects across the different wards that participants worked on. Worryingly perhaps, this was often framed as an example of staff being resilient, a more positive and valued quality required in staff working in mental health settings, and demonstrated a clear divide between those who had shut-off, and those who were less able to do so.

Will (Occupational Therapist): “You just have to get on with it. I mean that, I mean that is-I don’t necessarily agree with it, with that sort of approach to nursing or OTAing or whatever. But there is-in some elements, in some ways I do…at some point during people’s admission, or you know-that is probably a slight exaggeration, you’re gonna get either verbal abuse-you’re gonna get physical abuse. You’re gonna get-that will happen. So you need to be thick skinned”.

Lauren (Assistant Psychologist): "Or being like, weak, from not coping. That's a massive thing on my ward. Being weak. That's not allowed almost. You have to be strong and tough. Like a prison guard. Like 'oh if these things affect you, they shouldn't though'. Even though they're quite horrible things".

It seems that some of these attitudes have arisen from the ward itself and the culture created there, through staff attempts to desensitise to the incidents in order to continue to work in an environment where working with high-risk behaviours is commonplace and expected. Lauren's description of being like a prison guard also shows the negative impact this can have on the therapeutic environment. Furthermore, there is also a feeling that the need to be resilient and tough comes not only from colleagues who work on the wards with the staff members, but from higher management levels too, making challenging and changing this culture difficult.

Will (Occupational Therapist): "on the wards there's a sort of macho type approach to not talking about suicide, self-harm. You have to laugh it off. You have to, because-I've heard it said, and this is not my experience, but I've heard other people saying that if management see you breaking down then you're sort of in trouble. Not in trouble as in you get a warning, but they'll say 'she's weak. He's weak. Get them out'."

3.2.2.3 You have to remember they're unwell

As well as desensitising to the incidents that they are required to manage on a daily basis, staff further attempt to explain away these incidents by highlighting that the patients are unwell, something that appeared to help them to cope with being exposed to high-risk behaviours. It seems that at times staff are searching for an explanation that will protect them against the difficulty of working in this environment – that is, that patients are unwell and are less able to control their actions as result, rather than

an acknowledgement that some behaviours might not be related to mental illness, despite the fact that many staff themselves identified behaviour as a result of frustration and unmet needs, rather than a mental health issue.

Will (Occupational Therapist): "you need to be thick skinned. And you need to remember that they're unwell".

The need to identify patients as unwell, and to describe their behaviours as a result of this, also seemed important in mitigating against the impact of behaviour that was directed at individual staff members. They seemed to suggest that once the patient was feeling better, they would be able to apologise for their behaviour and would 'recognise' the staff member, perhaps suggesting that had they been well at the time they wouldn't have displayed this violence or aggression. It seems important to staff that this the case, and may help to defend against feelings of being vulnerable.

Pete (Doctor in Psychiatry): "…probably more at the time just realising that he's just having a bad day, he's just not well on that particular day, erm, that he will later on remember this and will probably apologise for it".

Jane (Nursing Associate): "They are so unpredictable. They are talking to you, being friends with you. I've had an incident where…he was aggressive towards other people and I got there and I was thinking 'oh well, I talk to him it will be fine'-he wasn't. The state he was in, he didn't recognise nobody, that was the state that he displayed. He couldn't even care that it was me…so, it's a lesson to anybody working in an acute ward or working in this kind of setting that there's a flip, the flip could just come up like that".

3.2.3 Theme Three: Current Systems for Managing

This theme explores the current ways that staff manage violence, aggression, self-harm and suicide ideation from a practical perspective, and what support systems are in place for staff after an incident has happened. The first subtheme, *practical incident management,* describes how staff deal with incidents in the moment, and whether they think this is effective. The second subtheme, *support systems: good, bad and absent,* identifies the current support systems in place for staff, whether they think these are helpful, and what they would like to be better in the future.

3.2.3.1 Practical Incident Management

Staff described a clear understanding of how incidents should be managed according to their ward guidelines, and generally felt that this was an area that was followed well by themselves and their colleagues. The described a number of interventions, ranging from verbal de-escalation, through to restraint and seclusion. The pressure of managing these incidents effectively was highlighted by staff who were wary of their reputation on sister wards, and also by staff who felt that there was little that could be done to manage some patients.

Karris (Occupational Therapist): "Yeah, when incidents happen it's-I think the emphasis-the highlight is focused more on the incident and like we don't wanna be seen as like a bad ward, because there's so many other wards here as well, and we don't want to have so many serious incidents and stuff like that so that's where-that's the important part really".

Allie (Ward Manager): "But there's some incidents where there's literally like nothing-that person is just a very angry person at the time, and there's very little you can do to try and minimise that".

Dan (Staff Nurse): “Very often you have patients being aggressive and violent towards other patients and staffs, and obviously we have seclusion, where we have to seclude that person to manage the risk to themselves or others”.

A number of staff referred to Safewards (Bowers, 2014), a conflict and containment model aimed at reducing the likelihood of incidents occurring and managing them more effectively with less need for physical intervention or seclusion. It seemed that staff using this intervention felt it was effective in allowing them to communicate with the patients and achieve de-escalation of an incident more successfully, reducing the levels of restraint and seclusion on the wards.

Allie (Ward Manager): “overall I think the team in general have used a lot of Safewards and things like that to reduce violence and aggression. Which is really good”.

Dan (Staff Nurse): “But a lot of times-the patients we’re receiving, when you talk to them, they listen, unless they’re very, very unwell. But most of the time we try to use verbal de-escalation rather than physical. So, our physical restraints have gone down a lot compared to previous years. So-‘cause staffs now are using more, like I say, Safewards interventions. So, we’re not having to restrain that much”.

Despite working in a challenging environment, Dan felt that the work he and his colleagues are able to do through the use of Safewards interventions, patience and teamwork reminded of him of why he had come to work in this particular setting in the first place, giving him a feeling of satisfaction in his work.

Dan (Staff Nurse): “I love working in a PICU [Psychiatric Intensive Care Unit] because we do-I believe all of us do a good job, because when we receive the patients they’re at their worst. Very aggressive. Very manic. But then after a few weeks you

see them in a different presentation. Very calm and interacting with us, so that gives you that satisfaction you know? It reminds you why you started that job in the first place".

3.2.3.2 Support Systems: Good, Bad and Absent

Staff were conflicted in their views relating to the support that was available to them following incidents on the wards. This seemed to vary by ward itself, and across profession. Staff who spoke of positive experiences of support following an incident always made reference to the fact it was their colleagues who they were on shift with at the time who had been to ones to reach out and check in with them.

Karris (Occupational Therapist): "…throughout the whole day staff was very-just like helpful. Always asking 'do you need a break? Do you wanna go on your break? Have you had your lunch yet?'. 'Cause we know it was quite a difficult day at work so it was important to kind of get off the ward and go and have a break".

Despite this, support on the wards was lacking. The individuals who described being able to access support were all in professions where clinical supervision is mandatory, and they were able to reflect on how this made them different from the other members of staff on the wards.

Lauren (Assistant Psychologist): "No. There's no debrief for them. There's-I will go up to them and ask like 'are you okay?'. They get shocked when I ask them that…No-one, I don't think, asks them. No-one asks me at the time, but I can reflect on it in supervision. I'm in that position where I can do that".

Despite having difficulty recalling experiences of support on the wards following an incident, particularly from a positive perspective, staff were able to recall experiences

of being offered support that had turned out to be unhelpful, even if this support came as a result of following ward procedures for managing an incident. Additionally, staff who had reported incidents on the dedicated incident report system felt that they still did not get any response from this. This in turn made it less likely that staff would seek out support in the future.

Will (Occupational Therapist): "I tell you what did affect me, actually…it was reported to the police. Because it was a physical attack. And then the police turned up the next day or so to interview me, and the policeman thought it was hilariously funny. And he said 'we've all been laughing about this back the, er, back at the thingy'. And he was saying 'where abouts between your legs?' and he was making a joke about it. And that I found like-at the time I was trying to laugh it off, I think I was trying to be a bit macho about it. But part of me was thinking 'fucking hell mate. If I see someone attack you in the street I wouldn't be making jokes about it'. It was as if-the sort of, what's the word? The erm, the sort of investigation was all wrong".

Jane (Nursing Associate): "…doing a Datix. Nothing came out of it. Nothing was done. Nobody approached me. I just had to deal with it myself. So that was it."

Dan (Staff Nurse): "All you're asked to do is complete a Datix and that's the end of it".

Perhaps even more concerning than staff experiences of negative support was the amount of people who reported that support was simply not available at all. Considering the NHS push to promote wellbeing in staff, and the offer of Occupational Health and confidential phone lines for staff who wish to speak to someone, this is worrying. It is suggestive that the NHS is inadequate in supporting the needs of its workers, and that not enough is being done to make them feel looked after and valued by their employer, both at a ward level and by the NHS as a whole.

Sue (Assistant Psychologist): "I've stood there and one will be shouting at me 'I wanna be discharged' and another will be shouting at me 'I want cigarettes', and then all three of them are shouting and wanting things…And I'm standing there thinking 'okay, anyone else gonna come out and speak to these patients with me? Or am I just gonna try and hold all three of them?'. So I kind of find that a bit frustrating".

Lauren (Assistant Psychologist): "On my ward debriefs don't occur-even after serious incidents that don't happen. And that is ridiculous".

Allie (Ward Manager): "I think historically nurses wasn't supported enough, by the police, by ourselves, by management. Erm, it was like the norm. Whereas as time is going on-because we're making such a big deal about things that are happening, incidents of aggression, violence, racial abuse, things like that, because we're making such a big deal out of it, erm, staff are kind of thinking 'this aint right, I don't come to work to do that, I'm actually gonna stand up for myself-not towards the patient-but this isn't right'."

Allie's comment shows that despite there being a culture of desensitisation and 'getting on with it' on the wards, there is a movement in the attitudes that staff have about their work, the incidents they are exposed to and what is expected of them. When asked what they think could be better, staff were often unable to think of exactly what it is they wanted, however, identified that something person centred that gave them space was a good place to start. There was also the recognition that a one size fits all approach would not work for these staff members and their colleagues.

Lauren (Assistant Psychologist): "I think they definitely need more support and space to like reflect and think. I don't know how they'll get it. Their demands are just too high. It's like there's no room. Even in team meetings-we have monthly team

meetings. The attendance is low. ‘Cause the staff are needed on the floor and we don’t book any other staff”.

Karris (Occupational Therapist): “We should be supported, even if it is verbal aggression, erm, we should still have somewhere we can just debrief with someone, how we’re feeling etcetera”.

Dan (Staff Nurse): “The way I handle the situation is different to how somebody else might handle the situation…I think there should be more support. I don’t know what kind of support, but I think there should be. I feel like staffs, and patients as well, when they go through traumatic experiences of just being assaulted, or experiencing stuff like attempted suicide or self-harm, there should be a little bit of support there for them. For them to express themselves and make sure that they’re mentally healthy and ready to work. ‘Cause a lot of times people stay quiet and no-one say anything, but it’s there, it’s affecting them”.

Whether support was good, bad or unavailable, and where the support came from, tended to vary across and also within professions. Pete, Georgia and Lauren (Doctors in Psychiatry and an Assistant Psychologist) reflected on the fact that they readily have clinical supervision available to them where they can go to reflect on incidents. Georgia acknowledged that this type of reflective space could be difficult on the wards, depending on who sets the narrative of the space. Allie (Ward Manager), Isobel (Nursing Associate) and Lauren (Assistant Psychologist) mentioned attempts for space to be provided to staff for reflection, but these were often difficult to attend as they wards were too busy, there weren’t enough staff to cover attendance, or people weren’t in the right frame of mind to attend.

Chapter Four: Discussion

4.0 Chapter Overview

This chapter summarises the findings of the study and discusses how they relate to the existing literature in this area. The study's strengths and limitations will also be critiqued here. Furthermore, recommendations regarding clinical practice within adult inpatient mental health services will be outlined, as well as suggestions for future research. Finally, due to the nature of the study a personal reflective account will be included.

4.1 Summary of findings

Participants were able to describe the immediate and longer-term consequences of exposure to patient high-risk behaviours in an adult inpatient setting, and how these impact on them individually and the staff team as a whole. Whilst some participants were able to reflect on these experiences and think about the impact of these on their own wellbeing, others found this particularly difficult, and would move the conversation on quickly, which appeared to reflect the culture of 'getting on with it' on the wards. There appeared to be a clear and significant split in discussions related to violence and aggression, compared to discussions related to self-harm and suicide ideation. Whilst staff felt that they were able to manage incidents of violence and aggression effectively, and often stated they were not emotionally impacted by these experiences, incidents of self-harm and suicide ideation seemed to leave staff feeling deskilled, defeated and had a noticeable emotional impact. Despite the differences in reactions to different types of risk, staff commonly spoke of the need to remember that the patients are unwell, which seemed to serve as a coping strategy following

exposure to risk incidents. Finally, the type and quality of support offered varied across different wards, and there was the narrative that seeking support indicates weakness, something that was felt to be present not only at a ward level, but also in higher management.

4.2 Staff experiences of violence and aggression

Working in an environment where you are exposed to incidents of violence and aggression caused staff to feel an increased sense of threat and vigilance whilst on shift. Exposure to lower risk incidents of violence and aggression also had a lasting psychological impact on staff, leading them to consider the consequences of what could have happened if the situation had been worse or escalated, and had a direct impact of their perceived sense of safety whilst on shift. As a result, staff reported a good knowledge base of how incidents of violence and aggression are managed on their wards, including the use of verbal de-escalation, restraint and seclusion, depending on the perceived severity of the incident, with maintaining a sense of safety being the key outcome.

From an evolutionary perspective, vigilance is fundamental to the identification and management of potential threat, and therefore to the likelihood of survival, by prompting a flight, fight or freeze response (Blanchard, Griebel, Pobbe & Blanchard, 2010). Staff working in acute mental health inpatient wards find themselves in a unique position in relation to the management of potential threats to their safety, as they often have to resist these innate responses in favour of carrying out their professional duties and supporting the patients and colleagues with whom they are employed to work. Instead of relying on evolutionary threat responses, staff teams

need to establish safety and hierarchy by defining characteristically different in-groups and out-groups, in this case, staff members (those in control and in a position to allocate punishment and reward) versus patients (those subject to enforced rules and boundaries which must be followed). Patient displays of violence and aggression towards staff members have the potential to displace the safety of the group systems and threaten the established hierarchy of the groups (Giammarino & Parad, 1986; Weisman et al., 2011). This puts staff under increased pressure to maintain the hierarchy and safety of themselves and others on the ward, often displayed through restraint and seclusion methods when incidents of violence and aggression are considered unmanageable through any other means. The management of the ward and the groups within it requires constant vigilance to the presence of threat, something which staff describe causes them to feel on-guard and to experience a persistent feeling of dread whilst on shift, which can also contribute to reported difficulty in switching off from incidents and lead to difficulty sleeping. These reported experiences support the existing literature on inpatient staff experiences of patient violence and aggression that document increased stress levels, poorer physical and mental health and the presence of PTSD related symptoms (Currid, 2009; Reininghaus et al., 2007; Whittington and Wykes, 1992) and which are a known contributing factor to staff burnout (Crabbe et al., 2002).

Furthermore, exposure to lower risk incidents caused some staff to consider how these might escalate, how they could have been worse, and what this might mean for their safety whilst on shift. Perceptions of increased risk and severity of violence and aggression are known factors for predicting the use of restraint and seclusion practices in psychiatric inpatient settings (Benedicts et al., 2011), therefore it was not

surprising that staff in this study reported willingness to use these strategies in order to manage incidents of violence and aggression according to ward protocol. Feeling secure in the decision to use restrictive practice interventions not only serves to protect staff at an individual level, but also helps to reinforce the hierarchy of the in-group/out-group division in psychiatric inpatient wards and demonstrates desirable in-group characteristics that are deemed important amongst the staff team (Kalma, 1991).

Staff knowledge of, and willingness to use, restrictive practice interventions to manage incidents of violence and aggression, along with the denial of the impact on incidents on them personally, suggests that staff may be experiencing emotional exhaustion and depersonalisation consistent with Maslach's (1982) theory of burnout. Staff described a need to shut themselves off from the incidents of violence and aggression that had occurred, and as a result this contributed to and maintained a ward culture where the impact of such incidents was not discussed. There was evidence of depersonalisation in relation to the management of incidents of violence and aggression, where staff referred to basic nursing tasks that needed to be carried out in these circumstances, such as maintaining safety and ensuring patients are fed, which suggests that staff detach from seeing patients as individuals in distress, and instead may view them as a particular 'case' that needs to be managed (Maslach, 1998; Menzies, 1960). Consistent with the literature on burnout, this also led to feelings of reduced personal accomplishment in staff, who acknowledged that they felt demotivated and deskilled in their abilities to effectively manage incidents alongside their own self-preservation.

4.3 Staff experiences of self-harm and suicide ideation

The experiences of staff exposed to incidents of self-harm and suicide ideation offer a stark contrast to experiences of violence and aggression. Whilst staff reported feeling under personal threat and responded to this by enforcing ward agreed management plans during incidents of violence and aggression, those dealing with incidents of self-harm and suicide ideation reported feeling emotionally overwhelmed by the situation, worrying about the safety of the patients under their care, and feeling incompetent in their abilities to work with incidents of this nature.

Being faced with the direct reality of the severity of patient situations and their internal distress, through exposure to self-harm incidents, caused staff to experience their own feelings of being emotionally overwhelmed. Whilst staff in inpatient mental health wards are employed to support the recovery of the patient, incidents of self-harm and suicide ideation may serve as a reminder of systemic failings in this area, and highlight the desperation felt by some patients. These feelings are consistent with the burnout literature, which shows that this occurs as a result of staff feeling emotionally exhausted due to frequent exposure to high-risk behaviours (Sullivan, 1993) and a sense of decreased personal accomplishment in their work (Maslach, 1998). Research has shown that high levels of both personal and practical support can mitigate against burnout in staff (Fenlason & Beehr, 1994; Sullivan, 1993), however, staff described a ward culture that was intolerant of emotional expression amongst the team, and professional detachment (Menzies, 1960) was encouraged through the detachment and denial of feelings, through the rhetoric that staff should ‘just get on with it’, and that demonstrations of emotions make you weak. This prevents the

opportunity for exploration and discussion of the impact of these incidents on staff, and therefore provides no way for staff to work through these feelings. Instead, organisational fears take hold within whole staff teams, who fear persecution from both their colleagues and members of management, thereby reinforcing the ward culture and preventing opportunity for change (Jacques, 1953).

As there is no space for the acknowledgement of the emotional impact of these events, the risk of burnout remains high. As staff continue to struggle with the management of these incidents, and the impact these have on them, they increasingly feel hopeless and deskilled. Staff reported feeling unsure how to practically support someone in this period of acute distress and feel as though they have failed to provide adequate care in understanding and supporting the patient emotionally during this time. Furthermore, feeling deskilled caused staff to worry about the safety of the patients in their care, and become fearful of what might have happened had they not discovered the patient in time, or had the patient not approached them for help. These feelings are consistent with the sense of reduced personal accomplishment in the burnout literature (Leiter, 1993; Maslach, 1998) and also contributes to the existing literature in this area that found staff struggle to make sense of incidents of self-harm and suicide ideation, and can feel responsible for the incidents due to difficulty in knowing how to manage the situation (Beryl et al., 2018; Rouski et al., 2017).

In terms of in group/out group differences and perceptions of social rank, staff described a conflict between what was deemed an acceptable response to these incidents. There was an underlying ward culture that suggested the best way to manage was to get on with the job. Staff that demonstrated emotional difficulties in

response to these incidents were sometimes viewed as unprofessional and weak. This then had implications for the staff member's sense of belonging to the group (Kalma, 1991), which further impacted on their perceived competence and ability to manage (Gilbert & Miles, 2000). Demonstrating undesirable qualities of weakness, rather than being 'resilient' to these incidents was warned against by ward staff, who reported that management would notice this 'weakness' and that this would have repercussions for the staff member involved. This, then, creates a further in-group/out-group distinction between ward staff, who need to show resilience and complete their tasks, and management, who have the ability to administer punishments if they feel staff are not working in an effective manner (Weisman et al., 2011). The denial of the impact these incidents have on staff, in favour of looking desirable and competent to their colleagues, can further contribute to a lack of personal accomplishment, emotional exhaustion and burnout (Crabbe et al., 2002).

4.4 Remembering the patients are unwell

It seemed necessary to staff to remember that the patients they worked with are unwell following incidents of violence and aggression on the ward. The purpose of this seemed to offer some protection to staff and help them cope with the emotional, and sometimes personally felt, impact of the incidents. If staff were able to explain away the patient behaviour as being a demonstration of their illness, they felt less persecuted by the incidents, which seemed to be the case following incidents of violence and aggression. Furthermore, this understanding of illness helps to reinforce the boundaries between the in-group and the out-group and may help to reinforce to staff that their restraint and seclusion processes are necessary to maintain safety and control. There was no indication that viewing the patients as unwell increased

compassion towards the patients, and so it seems this strategy was self-protective for staff. Interestingly, this is not something that has been explored in the literature concerning staff experiences of violence and aggression, but has been mentioned briefly in relation to self-harm and suicide ideation (Rouski et al., 2017).

4.5 Support for staff

Staff experiences of support were varied, with some examples of good support, examples of times when support had been poor, and times when support was felt to be completely absent. A narrative unfolded that suggested asking for or requiring support demonstrated a weakness within the member of staff who required it, and that this was present not only amongst work colleagues but also in positions of management. This created an in-group/out-group split, a 'them' versus 'us' rhetoric that led to staff having a negative perception of management and organisational systems in place. Staff who had completed the required paperwork following an incident felt that this had not resulted in any tangible outcome and felt let-down by this. It seemed that this became a task-orientated exercise with little room for considering the impact of the incident on the staff member affected, creating distance between management and their acknowledgement that the experiences of staff can be unbearable at times (Heginbotham, 1999). This demonstration of varied quality of support is also seen in the limited existing literature in this area – just one study in the systematic review considered the quality of staff support, and similarly the experiences of this were varied (Whittington & Wykes, 1992). Staff expressed a desire for more person-centred support, although they were not clear on what form this would take and felt this was a decision for management to make. In order to make the difficult experiences of working on the wards more bearable, and to reduce

the feeling that asking for support is risky and shows weakness, management need to develop an open and collaborative support system that can offer relief from these experiences, which additionally is shown to mitigate against the risk of burnout workload (Fenlason & Beehr, 1994; Sullivan, 1993).

4.6 Strengths and Limitations

Strengths: There is a scarce literature base exploring staff experiences of violence, aggression, self-harm and suicide ideation when working in an inpatient mental health hospital, particularly from a qualitative perspective. What does exist also tends to focus mainly on whether these experiences cause staff to present with symptoms of anxiety, PTSD and burnout, rather than homing in on and addressing the experience itself (O'Brien et al., 2013; Reininghaus et al., 2007; Renwick et al., 2019; Whittington & Wykes, 1992; Wykes & Whittington, 1998). Furthermore, literature tends to be split into exploring either violence and aggression, or self-harm and suicide ideation. This study is novel in the fact that it combines both experiences in one project, allowing for direct comparisons to be drawn between the different incidents. This has led to a novel insight not only in to the experiences of these incidents on staff members, but also demonstrates how different risk behaviours elicit difference responses from staff, in terms of both their perceived knowledge of and competency in practically managing the incident, and also how they manage and understand the emotional impact this can have on them.

In addition, the existing literature has little focus on how staff are supported following exposure to these incidents. This study demonstrates that, at most, staff find support from their immediate colleagues, but that this varies widely across different

wards. It highlights that staff do not feel cared for by the management system, and that at times the organisational procedures of reporting an incident can feel more like a ‘tick-box’ exercise, as this is rarely followed up on. Staff discussed the need to take all incidents, no matter how seemingly small, seriously. Furthermore, it highlighted the importance of management modelling a culture of care for its staff, as there was a narrative that asking for support meant you would be singled out as ‘weak’ by those higher up, and a culture of denial and ‘resilience’ spread across the wards as a result.

There was an attempt to maintain some homogeneity of the sample in this study, and as such only adult inpatient mental health wards were chosen as recruitment sites (Smith & Obsorn, 2003). Additionally, staff involved in the study were required to be employed by the Trusts used. This was to try to reduce variance in the experiences of staff, as agency staff may have different experiences due to working across a number of different wards and sites, and their support systems may be different to those employed directly by the Trust.

The chosen research methods for this study were suitable to address the aims of the study and were applied systematically and in line with documented guidance in the area. This helped to enhance the credibility and dependability of not only the gathered data, but also the way in which the data was gathered, and any personal impact the data collection had on the researcher which might influence the credibility of the results (Braun & Clarke, 2003; Lincoln & Guba, 1985). Furthermore, staff working in the area of adult inpatient mental health were consulted during the planning and development stage of the study, which allowed for study proposals to be reviewed and amended following input and advice from people with expertise in the area.

Additionally, the development and running of the study was supervised by a Clinical Psychologist working in the adult inpatient mental health environment, which ensured ethical codes were followed and provided guidance on how best to approach and recruit participants working in these environments.

It was important to clearly distinguish myself as a researcher in this context, rather than a clinician, whilst also developing rapport with participants and supporting them to discuss potentially emotive topics (Yanos & Ziedonis, 2006). As I was not, and had not, worked in the recruitment sites, there was no fear of boundaries being crossed and I was able to have open discussions with staff about their experiences without the interference of any concern that staff might then see me in a different context at a later time. Additionally, confidentiality and anonymity were reinforced both at the start and the end of the interview process, allowing staff to feel secure that they would not be able to be identified in the study write up.

Limitations: The participants in this study were self-selecting, and recruitment relied on people volunteering to take part in the study. Therefore, the data collected might be more representative of people who had a significant experience to report, an issue they felt they might want to express and share, or who felt strongly that taking part in research had the potential to make their voice heard or promote change, and therefore the experiences documented here may not be representative of the service as a whole. Additionally, there was a lack of Staff Nurses in this study, which may reflect the high stress this group of professionals are under when it comes to the day to day running of the ward, and therefore important insight from their perspective may be missing from this study.

Additionally, the recruitment process was challenging at times, and seemed to get off to a slow start. Staff work long and busy shifts, so were unlikely to volunteer themselves to attend an interview on their day off, or after their shift had ended. This limited most participants to taking part in their lunch break or being able to leave the ward at an agreed time with the shift leader. This may account for the number of people who initially agreed to take part in the study, but who later did not respond to follow-up emails attempting to arrange a date and time, or who had prearranged interviews but then did not attend, and who did not respond to email attempts to rearrange. To attempt to promote the study, the researcher attended the site on a number of occasions, speaking to staff at business meetings and prior to handover and ward rounds. The study was successful in recruiting a number of participants that fell within the recommended sample size for this type of research (Braun & Clarke, 2013), but it would have been preferable to increase this. It may have been beneficial to have made further attempts to contact staff who had shown interest in the study and to remind them of this, or to have spent more contact time at the research sites to reach a higher pool of staff.

Having 10 participants in this study falls at the lower end of the recommended sample size (Braun & Clarke, 2013). Whilst it was felt that data saturation was reached and no new themes were emerging from the data, it is possible that not all areas of this topic were explored as a result of a smaller sample. In addition, the sample contained a mix of professionals, including Nursing, Occupational Therapy, Psychiatry, Psychology and one Ward Manager. The numbers of each profession were low (Nursing = 3; Occupational Therapy = 2; Psychiatry = 2; Psychology = 2; Ward

Manager = 1), and combined with the small sample size this may mean that nuanced experiences from each profession were missed or not fully explored if they were not representative across the data set. It may have been preferable to focus on one staff group in order to mitigate against this.

It was important to consider research bias at all stages of the research process, and particularly during recruitment, interview and data analysis. Having previously worked in a number of mental health inpatient environments, I had my own experiences and ideas of the impact of incidents and support. Despite attempts to mitigate against this through the use of a reflective journal, it is unlikely that my own experience would not have had an impact on the study at some stage. As I was mindful of this, I made attempts to review each interview as novel and unique, and tried not to hold any preconceptions of what might emerge from the data.

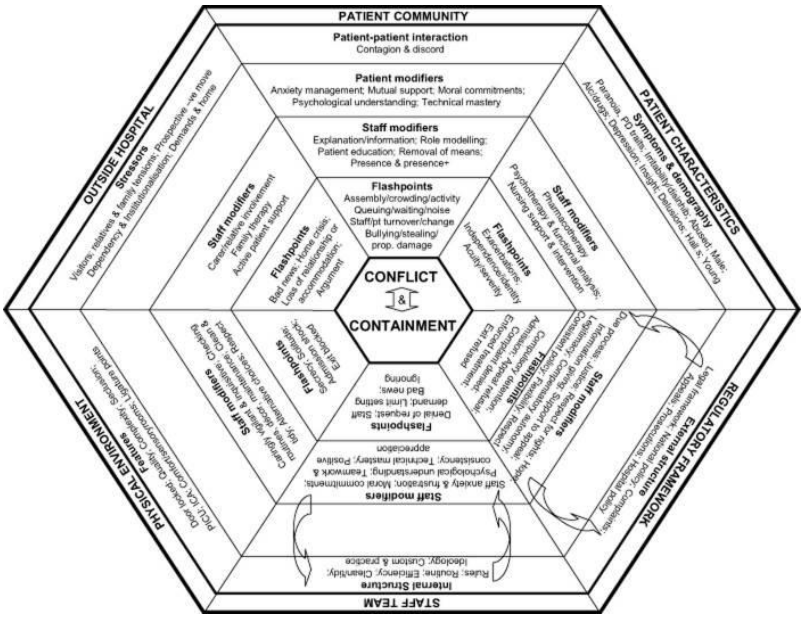
Finally, there was some variation in the type of adult inpatient mental health wards that participants were recruited from. Wards included acute, male only, female only, older adult and psychiatric intensive care units (PICU). Due to the variation in wards, patients may be at different stages in their recovery, therefore the experiences of staff may vary depending on which ward they work on. Additionally, you might find that some wards are more likely to experience incidents of violence and aggression, and others self-harm and suicide ideation. This was reflected in the interviews, with some participants having little to explore in either area as that type of incident was not typically experienced on the ward they work on. It might have been better to focus solely on one specific type of ward rather than the adult inpatient population

generally, however, practical limitations may then have contributed to increased recruitment difficulty and caused more challenges in this area.

4.7 Clinical Implications and Research

This study highlights key areas of importance for staff working in mental health inpatient environments. Firstly, it demonstrates that staff respond differently to different types of risk. According to this study, incidents of violence and aggression are felt to be generally well managed on the wards, and staff reported feeling competent in their abilities to practically manage these incidents. Furthermore, it seems that the use of Safewards interventions (Bowers, 2014) have been beneficial in reducing the need for restraint and seclusion on some wards. The Safewards model (*figure 1*) identifies key factors that are believed to influence conflict and containment rates on mental health inpatient wards, and proposes how staff and patients can modify their behaviours and interactions to prevent conflict and containment processes occurring (Bowers, 2014).

Figure 1 – The Safewards Model, from Bowers, 2014



Bowers (2014) identified six key factors thought to influence conflict and containment rates, including the staff team, the physical environment, outside hospital, the patient community, patient characteristics and the regulatory framework. The key features of the staff domain concern the rules imposed on patients by staff, the often strict routine of the ward, staff ideology concerning the purpose of the ward environment and what it offers to the patients, the effectiveness and efficiency of ward operations and the agreed practice among the staff team about how to manage times where patients are disruptive to the ward and its routine. Staff modifiers in this domain to reduce the rates of conflict and containment include regulating their emotional responses to patient behaviours that challenge the ward environment, maintaining an honest, non-judgemental stance, developing psychological understanding of patient behaviour, colleague support to practically and emotionally manage the challenges of working in these environments and developing skills in comforting and de-escalating distressed patients. The physical environment domain concerns features such as locked doors, seclusion rooms, the quality of the environment and the layout of the environment (which may make it harder for staff to effectively supervise patients). Staff modifiers include ensuring repairs and maintenance are a priority and the environment is well looked after, attempts to personalise the environment through patient choice of decoration and furnishings to make the environment more comfortable, and effectively observing patients in way that is engaging and shows interest in them, particularly when noticing and responding to indications of distress. The outside hospital domain concerns the patient's interactions with their friends and family, as well as life stressors concerning housing and financial difficulties. Staff modifiers include developing a strong

knowledge base of the patient's social circumstances and social network, and supporting them in managing and regulating these, particularly if they are stressful or involve elements of conflict. The patient community domain concerns the level to which patients are likely to 'copy' disruptive or risky behaviours of others, and discord between patients, which can increase anxiety levels and give rise to conflict. Staff modifiers include supporting patients to live and respond positively to each other during their admission, through role modelling skilled responses to complex behaviours, providing education and explanations on different psychiatric conditions and symptoms to enhance patient understanding of their own difficulties, and the difficulties of others, and developing positive therapeutic relationships with patient that allows for early intervention to prevent an escalation of conflict when it arises. The patient characteristics domain concerns the symptoms some patients display which may give rise to conflict, such as paranoia and delusions, depression, drug and alcohol use. Staff modifiers include the efficient provision of effective treatment, both psychological and pharmacological, and providing reassurance and support to patients who are displaying these behaviours. The regulatory framework domain concerns constraints imposed on patients such as detention under the Mental Health Act, national policy on treatment procedures in mental health inpatient units, and hospital policies concerning complaints, appeals and the prosecution of patient assaults and other criminal behaviours. Staff modifiers include showing respect for patient rights and providing advocacy and accurate information to patients concerning their detention, treatment and right to appeal, and providing a sense of hope of forward planning for the future. As the focus of this study did not include in-depth exploration of interventions, it is unclear which ward and staff teams are using Safewards interventions (Bowers, 2014), who feels confident in using them, and the extent to

which the different elements are applied. However, those who did discuss this intervention felt positive in their abilities to use the strategies identified, and felt this was beneficial. Therefore, it might be useful for Trusts to ensure all staff are trained in this way of working, and staff may also benefit from yearly refresher updates on how to use these skills in practice.

In contrast to how staff felt in managing incidents of violence and aggression, staff reported feeling less knowledgeable about how to practically manage and support patients who display self-harming behaviours and suicidal ideation. In addition, the emotional impact of these incidents tended to differ from incidents of violence and aggression. Staff tended to explain away the behaviour seen in violent and aggressive incidents as the patient being 'unwell', which seemed to offer some personal protection against the incident. However, in incidents of self-harm and suicidal ideation, staff reported feeling overwhelmed with the emotion of the patient, and of their own emotions in relation to what had happened. There was a sense of failure after repeated attempts to unsuccessfully manage these incidents, causing staff to feel deskilled and defeated. Also, support following incidents was lacking, and there was the sense that asking for support showed 'weakness'. Staff who felt most supported and able to manage incidents appeared to be those who regularly received clinical supervision, or who had a regular space in which to discuss their experiences, though this was not always the case.

In the first instance, the training needs of staff working with patients who display self-harm and suicidal ideation behaviours should be assessed. Training needs to ensure that it offers not only practical advice on how to manage patients in these

situations but should also bring awareness to the emotional impact of this work. Some of the interventions suggested from the Safewards model (Bowers, 2014) go some way to addressing this, such as developing a psychological understanding of different mental health presentations and behaviours, and how to practically manage distress in patients. Indeed, staff own suggestions in this area concerned how to support patients in the moment as distress and self-injurious behaviours are happening, as they felt their current methods were ineffective, which led to feelings of failure and demotivation. Considerable thought should be given on how to encourage staff to reflect on the emotional impact that these incidents can have on them. Whilst staff receive monthly supervision, this is often from a management and operational perspective. It may be beneficial, therefore, to provide clinical supervision for all staff working in inpatient mental health environments, not just those with professional registration. Clinical supervision provides staff with the opportunity to reflect on their own practice, and to develop their knowledge and competence in working with patients who display distress behaviours (Bland & Rosse, 2005; Jones, 2006). Without this space to reflect, staff may not have the opportunity to talk through challenges they face when working with specific risk behaviours, or to address areas where further training may be beneficial. In addition, it allows staff a confidential space to discuss the emotional impact of working with distressed patients. By offering clinical supervision to all staff, there is the opportunity for management to model good practice in supporting others and in 'containing the container' (Toasland, 2007), which may help to reduce the idea that asking for support is a sign of weakness and should be avoided. This opportunity to reflect on the emotional impact of the work in clinical supervision may also help to improve the emotional capacity required to

manage these incidents, which may directly impact on staff abilities to manage and supports patients during periods of increased distress.

Cookson (2014) highlighted that the quality and frequency of clinical supervision varied among registered staff. In order for clinical supervision to be the most beneficial to staff, it is recommended that a supervision model is adhered to, so that quality and consistency can be provided. Furthermore, it is important that clinical supervision is provided by someone other than the line manager. Staff members whose clinical supervisor is also their line manager show greater dissatisfaction with their supervision, and providing an alternative may help to mitigate against issues relating to power and confidentiality (Bush, 2005; Sloan & Grant, 2012). Finally, providing regular clinical supervision for all staff in inpatient environments may help to mitigate against burnout, sickness and staff-turnover (Cookson, 2014). This is turn may help the NHS to be less reliant on agency workers, which may help to reduce NHS spending in this area, increase the stability of the workforce on the ward, and therefore provide a more stable environment for the patients.

One of the important findings of this research is the impact that a perceived negative and judgmental ward culture, and wider organisational culture, had on how comfortable and able staff felt to voice that they needed support or were impacted by the high-risk behaviours they were exposed to. Research has shown that the culture of an organisation impacts on staff attitudes towards their work, including job satisfaction and their commitment to the organisation, the quality of service that is provided and staff turnover rates (Glisson & James, 2002). Organisations may adopt different approaches to leadership, such as transformational (where leaders are

supportive and helpful of staff members to adapt and change programmes and approach to meet the constantly shifting needs of the patients they provide care for) and transactional (where leaders attend to the day-to-day tasks involved in operating a service, and expect staff members to complete these tasks as instructed)(Corrigan, Diwan, Campion & Rashid, 2002). Research has suggested that transformational leadership where organisational and team goals are achieved through consideration of staff interests, inspiration and intellectual stimulation leads to lower levels of staff burnout and a more positive organisational culture, whereas the opposite is suggested for transactional leadership, where involvement only tends to occur when a problem arises that needs resolving, and appears detached from the staff team (Corrigan et al., 2002). Therefore, it may be of interest for senior management members to work in a way that is supportive, encouraging of staff members and responsive to their needs and concerns, and has more of a presence among the staff team, perhaps through organising visits to the ward or attending the regular business meetings that ward staff hold.

Based upon the findings and limitations of this study, it might be beneficial for future research to explore the systematic and structured use of clinical supervision for all staff members working in inpatient mental health environments. It may also be helpful to explore how management can model supportive work environments, and the impact this has on the ward culture. Finally, it may be useful to explore staff experiences of violence, aggression, self-harm and suicide ideation in other mental health inpatient environments, such as forensic, child and adolescent and learning disability services. This will help to identify the unique narratives around these

incidents and the impact of them on staff from a variety of settings, which may identify similarities or differences in staff experiences.

In summary, this study offers the following recommendations:

1. Consider giving staff further training on managing high-risk behaviours. This should target the difficulties staff reported with supporting self-harm and suicidal patients, but should also focus on how to manage the emotional impact of working with these patients. The Safewards Model (Bowers, 2014) might be a good option to start this training process.
2. Consider offering staff a reflective space to think about how their work impacts on them. Ideally, this would benefit from being individual to each staff member, and outside of their regular supervision. Research also suggests this should be facilitated by someone other than the line manager (Bush, 2005; Sloan & Grant, 2012).
3. Consider higher management having more presence on the wards. Staff reported feeling unheard by higher management, and would have liked follow-ups from incident reporting. Additionally, management should aim to promote a reflective and open culture to discuss some of the challenges of working in this environment. This may help to mitigate against the narrative that asking for support is a sign of weakness, as was reported by some members of staff.

4.8 Personal Reflective Account

Throughout this study I have attempted to be reflective and consider how the research I am doing has impacted on me and my work. I was drawn to this topic following my

own experiences of working in inpatient mental health settings, across a variety of contexts, including child and adolescent and forensic services, and in a variety of roles, from support worker, to assistant psychologist and then trainee clinical psychologist. I was mindful that my role progression through the services has changed my outlook on what it is like to work in these environments, and also that this could impact on how I interview and interpret the data from this research. Therefore, I felt it was important to keep a thorough reflective journal at all stages of the study process, and to remind myself of my role as an outside researcher, not someone who is currently working in this environment.

Despite knowing, from my own experience of working busy and long shifts, that it would be difficult to recruit participants in this area, I nonetheless experienced some significant frustrations and feelings of panic when this came to fruition. I first attended handovers and meetings on the wards in order to promote my study and felt disheartened at times when there appeared to be a lack of interest from staff. At times, I felt like an inconvenience in these meetings, which might have impacted on my ability to promote the importance of the study. However, there were other times when staff displayed enthusiasm and engagement with the topic, and this made me feel hopeful that people would volunteer to take part. This then led to feelings of disappointment when there was no response to emails attempting to arrange interview dates and times, and indeed to follow-up emails trying to chase this. If I were to carry out this research again, I would try to spend even more time on the wards promoting my study, and to not be fearful of ‘harassing’ staff members by sending follow-up emails.

I noticed during the interviews that some members of staff were reluctant to talk about the personal and emotional impact their experiences might have had on them. On reflection, I have probably taken for granted the role that my own supervision has on allowing me to develop my skills in exploring this aspect of my own work, and that it is something I have developed competence in and can now do with relative ease. I had underestimated the need to protect oneself against the daily occurrences of the ward, and to carry on with resilience despite the challenges that might be faced during a given shift. Therefore, when participants quickly skipped over this topic to discuss something else, I found myself torn between following their narrative, and with wanting to go back and explore things further. I feel there were times, particularly during the first few interviews, that I could have been more curious about this and asked follow-up questions, though this is a skill I felt I developed as I became more experienced in the interview process.

The interview process and subsequent data analysis reminded me of my own experiences of working in mental health inpatient environments, and I was saddened, though not shocked, to see similarities between my experiences and the experiences of the participants. The acceptance of repeated exposure to high-risk incidents, and the lack of support following this, combined with a sometimes negative ward culture, appeared common-place and 'part of the job'. To hear that this stemmed from ideas that management would perceive a need for support as 'weak' was saddening. Throughout my doctoral training, I have developed a sense of care and compassion not just for the clients I work with, but also the staff team of which I am a part. It is my goal that, once qualified, I will be able to demonstrate support and compassion, and the importance of reflection, to my colleagues. The idea that there is the potential

for me to be seen as otherwise was something I had not considered. Therefore, this has encouraged me to continue to develop my leadership and management skills, so that I can respond to the needs of my colleagues with the same care and compassion as I do to the needs of my clients. I feel this will be particularly beneficial to my future career, particularly as my career progresses to include supervisory and management roles.

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Appendix A – Systematic Review Search Strategy

The databases Web of Science, Medline, CINAHL, psycINFO and psycARTICLES were initially searched for literature in January 2019, and updated in January 2020.

The search terms for articles were as follows:

staff* OR employee* OR “support worker*” OR “care worker*” OR professional* OR “team member*”

AND

abuse OR assault* OR attack* OR violence OR “self harm” OR “self injur*” OR suicid*

AND

inpatient OR "mental health unit" OR "psychiatric unit" OR "psychiatric ward" OR "secure ward" OR "secure hospital" OR "mental health service"

AND

experience OR effect OR impact OR consequence OR exposure

Inclusion Criteria	**Justification**
1. Acute mental health inpatient context	1. Focus of the review
2. Within a NHS setting	2. Focus of the review; alternative settings may differ in their support systems
3. Qualitative and quantitative studies	3. To capture all available accounts
4. Incidents of exposure to violence, aggression, self-harm or suicide ideation	4. Focus of the review

Exclusion Criteria	Justification
1. A focus only on assessing risk or frequency of incidents	1. Not relevant to the study aims
2. A focus only on the management of incidents	2. Not relevant to the study aims
3. A focus on staff education, attitude or training needs	3. Not relevant to the study aims
4. Non-NHS settings	4. Support systems may differ across contexts, and the study focuses on NHS contexts
5. Non-English texts	5. Translation services not available; to support reading and critique in the author's first language

A total of 3130 articles were identified from the initial database searches. 165 articles were removed due to being non-English texts and 932 articles were removed as duplicates, leaving 2033 papers to be screened for review. Papers were first screened by title, and 1857 papers were excluded from the review due to not meeting the inclusion criteria. The remaining 176 papers were screened at abstract level, with a further 110 articles removed due to not meeting the inclusion criteria. The remaining 66 articles were reviewed at full text level. 56 full text articles were excluded due to not meeting the inclusion criteria, leaving 10 full text articles eligible for review. This process can be seen in *Figure 1.*

Figure 1 – Flow Chart of Study Selection

Appendix B – Systematic Review Articles

Characteristics of articles involved in the review examining the experience of witnessing violence, aggression, self-harm or suicide on NHS inpatient staff, in chronological order (N = 10)

Authors	Aims	Participants	Identified Experience	Quantitative or Qualitative	Main Results
Renwick et al., (2019)	To describe the physical and mental health and well-being of staff working on inpatient MH units. To explore whether there is a link between exposure to violence in the past year and the	384 staff (qualified nurses, healthcare assistants, occupational therapists and 'other)	Exposure to physical violence	Quantitative	Poorer physical health was found for those over 40, those who had been longer in post and healthcare assistants as compared to other staff groups. Poorer mental health was found in younger people, those who had been longer in post and

	physical and mental health of staff.				qualified nurses as compared to other staff groups.
Beryl et al., (2018)	To understand the experience of providing nursing care to female inpatients in a high secure inpatient MH unit.	7 staff (two team leaders, two nursing assistant, two qualified nurses)	Exposure to self-harm and physical violence	Qualitative	Four main themes emerged: horror, emotional hard labour, balancing acts and community, with a meta-theme of making sense by understanding why.
Rouski et al., (2017)	To understand the impact of self-harm on staff in inpatient MH units, perceived confidence of staff working with self-harm, and access to support.	5 staff (two nurses, two healthcare assistants, one teacher)	Exposure to self-harm	Qualitative	Six main themes emerged: the journey of adaption, the personal impact: feeling responsible, the nature of self-harm, the quest to understand, finding support in the

					team and risk management plans: creating clarity and certainty?
Jeffery and Fuller (2016)	The experience of nurses working on a PICU who had been exposed to violence in the past six months.	10 qualified nurses	Exposure to violence	Qualitative	Five main themes emerged: wanting holistic control, feeling responsible, making the right decision, dealing with feelings and wanting cohesive support.
Jussab and Murphy (2015)	To explore how psychologists process violence and the impact this has on the therapeutic relationship.	7 psychologists (4 clinical psychologists, 3 counselling psychologists)*	Exposure to verbal and physical violence	Qualitative	Three main themes emerged: processing the moment-to-moment experience of violence, professional vulnerabilities and

					needs as a result of violence and ruptured therapeutic relationships.
O'Brien et al., (2013)	To understand the number, type and impact of assaults on staff working on a PICU. To explore staff attitudes towards assault.	26 staff (11 qualified nurses, 11 nursing assistants, 4 doctors)	Exposure to verbal and physical violence	Quantitative	Assault included being spat at, punched, bitten, kicked and racially abused. Ten felt the assault had negatively affected their work, 7 needed time off work (range of 2-30 days). Staff reported feeling angry, having low morale, difficulty concentrating on their work and being shaken by the experience.

Currid (2009)	To explore occupational stressors, the experience of stress and the meaning of this experience on staff working in MH inpatient units.	8 qualified nurses	Exposure to violence and aggression	Qualitative	Three main themes emerged: pressures, violence and aggression and an inability to switch off from work.
Reininghaus et al., (2007)	To explore the role of stress resistance resources in the stress of inpatient nurses following physical assault.	636 nurses	Exposure to physical assault	Quantitative	Being physically assaulted was significantly correlated with psychological distress. Having a wider range of coping strategies, high levels of self-esteem and self-confidence was strongly associated with lower psychological distress. Assaulted staff were more likely to

					perceive their work as more stressful, environment as more dangerous and less likely to perceive they had good support outside work.
Wykes and Whittington (1998)	To understand the prevalence of traumatic (and other) stress symptoms in nurses working on inpatient MH units who have been assaulted. To understand how physical injury and stress load are related to immediate and later reactions to assault. To understand	39 qualified nurses	Exposure to physical assault	Quantitative	5% of nurses displayed psychological effects of trauma reaching caseness for PTSD. On the IES five people and ten people scored more than one SD above the mean on the intrusiveness and avoidance scales respectively. Anger and depression elevated

	how immediate reactions to assault are related to later reactions.				immediately after the incident, then later returned to normal.
Whittington and Wykes (1992)	To explore the nature of inpatient staff reactions to assault and the level of support provided to staff following an assault.	24 staff (23 nurses and one doctor)	Exposure to physical assault	Quantitative	Two staff members reported anxiety, and four strain, more than one SD above the mean up to 14 days after the incident. Fatigue and irritability were experienced more than other symptoms at 72 hours post-incident, with intrusive thoughts and nightmares more prominent after 14 days. Staff tended to smoke and drink more 72

			hours after the incident, though this rapidly declined. Two thirds of staff had been offered time to talk within 72 hours of the incident, though only eight had the opportunity to talk to someone of a higher grade than themselves, and the majority only spoke to someone at home. Only two staff were encouraged to take time off their shift after an incident occurred.

MH = Mental Health; PICU = Psychiatric Intensive Care Unit; PTSD = Post-Traumatic Stress Disorder; IES = Impact of Events Scale

*Information from psychologists working in the community excluded from this review

Appendix C – Quality Appraisal of the articles

Quality Rating Scores for Quantitative Articles, in Chronological Order

	Renwick et al., 2019	O'Brien et al., 2013	Reininghaus et al., 2007	Wykes and Whittington, 1998	Whittington and Wykes, 1992
Question/objective sufficiently described?	2	2	1	2	1
Study design evident and appropriate?	2	1	1	2	1
Method of subject/comparison group selection described and appropriate?	2	1	1	1	1
Subject and comparison group characteristics sufficiently described?	2	1	1	1	1
Random allocation described?	-	-	-	-	-
Investigator blinding reported?	-	-	-	-	-

Subject blinding reported?	-	-	-	-	-
Outcome measures well defined and robust?	1	1	1	2	1
Sample size appropriate?	2	1	2	1	1
Analytic methods described/justified and appropriate?	2	2	2	1	1
Some estimate of variance is reported for the main results?	2	1	2	1	0
Controlled for confounding?	2	-	2	1	0
Results reported in sufficient detail?	2	1	2	1	1
Conclusions supported by the results?	1	1	2	2	2
Quality rating (total sum/total possible sum)	0.91	0.60	0.77	0.68	0.45

- Not applicable for study; 0 Criteria not fulfilled; 1 Criteria partially fulfilled; 2 Criteria fulfilled

Quality Rating Scores for Qualitative Articles, in Chronological Order

	Beryl et al., 2018	Rouski et al., 2017	Jeffery and Fuller, 2016	Jussab and Murphy, 2015	Currid, 2009
Question/objective sufficiently described?	2	2	2	2	2
Study design evident and appropriate?	2	2	2	2	2
Context for the study clear?	2	2	2	2	2
Connection to a theoretical framework/wider body of knowledge?	1	2	2	1	2
Sampling strategy described, relevant and justified?	2	1	2	1	0
Data collection clearly described and systematic?	2	1	2	1	1
Data analysis clearly described and systematic?	2	1	1	2	1

Verification procedures used to establish credibility?	2	2	2	2	2
Conclusions supported by the results?	2	2	1	2	2
Reflexivity of the account?	0	0	1	1	0
Quality rating (total sum/total possible sum)	0.85	0.65	0.85	0.80	0.70

- Not applicable for study; 0 Criteria not fulfilled; 1 Criteria partially fulfilled; 2 Criteria fulfilled

Appendix D – Systematic Review themes

Four main themes, and eight subthemes, were identified from the systematic review exploring NHS mental health inpatient staff exposure to violence, aggression, self-harm and suicide ideation.

Main Themes	Subthemes
1. Negative impacts on health and wellbeing	A. Poorer physical health related to violence and aggression
	B. Poorer mental wellbeing related to exposure to high-risk incidents
2. Challenges to the provisions of care and competent working	A. Perceived incompetence in working with high-risk behaviours
	B. Feeling emotionally conflicted towards patients
3. The impact of the ward climate and perceptions of support	A. Positive experiences of support and helpful ward environments
	B. Inadequate support and unhelpful ward environments
4. Persistent feelings of fear	A. Prolonged sense of fear for own safety
	B. Ongoing concern for the safety of others

Appendix E – Participant Information Sheet

Participant Information Sheet for Working with psychological distress on NHS inpatient wards: A qualitative exploration of staff experiences and the support they receive

You are invited to take part in the above research project. Before you decide whether you would like to be involved, it is important that you understand why the research is being carried out, and what is involved. Please read the following information carefully, and feel free to discuss this with others. If you need more clarity or would like further information, please contact the researchers using the details at the bottom of this page.

What is the project?

This project is being conducted as part of the Doctorate in Clinical Psychology programme at the University of Essex. It aims to explore NHS inpatient staff experiences of exposure to patients in psychological distress. Patients displaying psychological distress may engage in self-harming behaviours, suicide attempts and aggression and violence towards others. This research builds on the existing literature in this area and will allow the research team to develop a rich understanding of the experiences of staff, create proposals for future research and has the potential to inform NHS policies.

Am I suitable to participate?

If you have experienced a patient displaying self-harm, suicide attempts, aggressive or violent behaviours whilst you have been at work then you are eligible to take part in the research project.

Do I have to take part?

Participation in the research project is voluntary – it is your choice whether or not you choose to take part. If you do decide to take part, you will be able to keep a copy of this information sheet for future reference, and will be required to sign a consent form agreeing to take part. You can withdraw from the project if you change your mind, and you do not have to give a

reason for doing so. If you choose to withdraw from the project all identifiable data collected will be withdrawn from the study. Data that is not identifiable may retained.

What does taking part involve?

If you choose to take part, you can contact the research team directly using the email address listed at the bottom of the page, or alternatively you can complete the tear-off slip at the bottom of the page, and a researcher will contact you to arrange a time to meet with you. This meeting will take place at your place of work. Once consent has been agreed, you will be asked a few questions about your experience of the abuse, and any support you received. The interview will take approximately 45 - 75 minutes, depending on how much information you give. The interview will be audio recorded using a Dictaphone. Data from your interview will be transcribed by the Chief Investigator, Miss Emma Rivett. You may be contacted at a later date to check themes identified within the data for accuracy, if you wish to be involved in this stage. Quotes from your interview may be used in reports and publications, and will be anonymised. You may be contacted at a later date

What are the possible disadvantages of taking part?

This project may cause some distress if you find talking about the incident difficult or upsetting. You are welcome to take a break in the interview if this occurs, or to stop the interview altogether. You will be offered a debrief following the interview to discuss any feelings of distress that may have arisen.

What are the possible benefits of taking part?

It is hoped that the findings of this project will help to gain a deeper understanding of the experiences of staff who are exposed to patients experiencing psychological distress, and what support they receive. This can help to inform service improvements and NHS policies, allowing for developments to be made where required.

Will my information be confidential?

Yes, all information about you will be kept confidential. Your data will be anonymised in any reports or publications. Data will be stored using password protection, and will be in keeping with the University of Essex Data Protection Policies. Data collected may be reviewed for auditing purposes, but this will remain confidential.

What will happen to the results?

Results will be written up in a thesis project as a requirement for the completion of the Doctorate of Clinical Psychology course at the University of Essex. Reports will also be disseminated to the services involved, and publication in journals with be sought. You can also request to have a report of the results sent to you.

How will my information be used?

The University of Essex is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. The University of Essex will keep identifiable information about you for five years after the study has finished. Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible. You can find out more about how we use your information by contacting the Information Assurance Manager on [redacted]

Miss Emma Rivett will keep your name and contact details confidential and will not pass this information to The University of Essex. Miss Emma Rivett will use this information as needed, to contact you about the research study, and make sure that relevant information about the study is recorded for your care, and to oversee the quality of the study. Certain individuals from the University of Essex and regulatory organisations may look at your research records to check the accuracy of the research study. The University of Essex will only receive information without any identifying information. The people who analyse the information will not be able to identify you and will not be able to find out your name or contact details. Miss Emma Rivett will keep identifiable information about you from this study for five years after the study has finished.

Who has approved this project?

The project has received HRA approval from the NHS and sponsorship from the University of Essex. Ethical approval has been granted for this projects from the University of Essex Faculty of Science and Health Ethics Subcommittee.

What if I have a complaint?

If you have any concerns or complaints about this project in the first instance you can contact a member of the research team:

Emma Rivett (Trainee Clinical Psychologist) – [redacted]

If you are not satisfied with the response you have gained from the researchers in the first instance, please contact:

[redacted]

If you remain unsatisfied and wish to complain formally, you can do this by contacting the

[redacted]

Research Project Team:

[redacted]

Emma Rivett, Trainee Clinical Psychologist – [redacted]

Thank you for taking part in this research.

Contact Slip

Please contact Emma Rivett (Trainee Clinical Psychologist) on [redacted] if you are interested in being involved in this project.

Alternatively, complete the slip below and place it in the envelope provided. Please leave this envelope with the receptionist, and the researcher will collect them and be in touch.

I would like to take part in the research project examining the experience of abuse on NHS inpatient staff, and the support they receive.

Name:_____

Place of work:_____

Role:_____

Email:_____

Appendix F – Participant Consent Form

University of Essex

[redacted]

Participant Name:

Participant Number:

Participant Consent Form for Working with psychological distress on NHS inpatient wards: A qualitative exploration of staff experiences and the support they receive

	Please Initial
1. I have read and understood the Information Sheet dated 01/02/2019 (Version 1.1).	
2. I have been given the opportunity to ask questions about the project and have had these answered.	
3. I agree to take part in this project.	
4. I am aware that this will involve being audio recorded.	
5. I understand that taking part in this project is voluntary. I am aware that I can withdraw from the project and that I am not required to give reasons for my choice to withdraw. If I withdraw from the project, I am aware that all identifiable data collected will be withdrawn from the study. Data that is not identifiable may retained.	
6. I understand my personal details are confidential and will not be shared with anyone outside of the research project.	
7. I understand that my words may be quoted in publications, reports and other research outputs, but that data will be anonymised.	
8. I understand that my data will be stored securely in line with the University of Essex's Data Protection procedures.	
9. I understand that auditing bodies may request access to my anonymised data.	
10. I agree to be contacted at a later date to be involved in checking themes derived from the collected data for accuracy.	

Name of participant	[printed]	Signature	Date
Researcher	[printed]	Signature	Date

IRAS ID 249234
Version 1.1
01/02/2019

Appendix G – NHS Ethical Approval

Ymchwil lechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Miss Emma Rivett
[redacted]

Email: hra.approval@nhs.net
Research-permissions@wales.nhs.uk

01 February 2019

Dear Miss Rivett

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Working with psychological distress on NHS inpatient wards: A qualitative exploration of staff experiences and the support they receive**
IRAS project ID:	**249234**
Sponsor	**University of Essex**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

How should I continue to work with participating NHS organisations in England and Wales?
You should now provide a copy of this letter to all participating NHS organisations in England and Wales, as well as any documentation that has been updated as a result of the assessment.

Following the arranging of capacity and capability, participating NHS organisations should **formally confirm** their capacity and capability to undertake the study. How this will be confirmed is detailed in the "*summary of assessment*" section towards the end of this letter.

You should provide, if you have not already done so, detailed instructions to each organisation as to how you will notify them that research activities may commence at site following their confirmation of capacity and capability (e.g. provision by you of a 'green light' email, formal notification following a site initiation visit, activities may commence immediately following confirmation by participating organisation, etc.).

It is important that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details of the research management function for each organisation can be accessed here.

IRAS project ID	249234

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within the devolved administrations of Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) has been sent to the coordinating centre of each participating nation. You should work with the relevant national coordinating functions to ensure any nation specific checks are complete, and with each site so that they are able to give management permission for the study to begin.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?
The attached document *"After HRA Approval – guidance for sponsors and investigators"* gives detailed guidance on reporting expectations for studies with HRA and HCRW Approval, including:

- Registration of Research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

I am a participating NHS organisation in England or Wales. What should I do once I receive this letter?
You should work with the applicant and sponsor to complete any outstanding arrangements so you are able to confirm capacity and capability in line with the information provided in this letter.

The sponsor contact for this application is as follows:

[redacted]

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **249234**. Please quote this on all correspondence.

IRAS project ID	249234

Yours sincerely

[redacted]
Assessor

Email: hra.approval@nhs.net

Copy to: [redacted]

IRAS project ID	249234

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Indemnity Letter]	Version 1.0	16 July 2018
HRA Schedule of Events [Validated SOE]	1.0	01 February 2019
HRA Statement of Activities [Validated SOA]	1.0	01 February 2019
Interview schedules or topic guides for participants [Interview schedule]	Version 1.0	24 September 2018
IRAS Application Form [IRAS_Form_29012019]		29 January 2019
Letter from sponsor [Letter from sponsor]	Version 1.0	07 January 2019
Participant consent form [ICF]	1.1	01 February 2019
Participant information sheet (PIS) [PIS]	1.1	01 February 2019
Research protocol or project proposal [Qualitative Protocol]	Version 1.0	02 December 2018
Summary CV for Chief Investigator (CI) [CV]	Version 1.0	06 November 2018
Summary CV for student [CV]	Version 1.0	06 November 2018
Summary CV for supervisor (student research) [Supervisor CV]	Version 1.0	06 November 2018
Summary CV for supervisor (student research) [Supervisor CV]	Version 1.0	06 November 2018
Summary, synopsis or diagram (flowchart) of protocol in non-technical language [Summary timetable]	Version 1.0	24 September 2018

IRAS project ID	249234

Summary of assessment

The following information provides assurance to you, the sponsor and the NHS in England and Wales that the study, as assessed for HRA and HCRW Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England and Wales to assist in assessing, arranging and confirming capacity and capability.

Assessment criteria

Section	Assessment Criteria	Compliant with Standards	Comments
1.1	IRAS application completed correctly	Yes	No comments
2.1	Participant information/consent documents and consent process	Yes	No comments
3.1	Protocol assessment	Yes	No comments
4.1	Allocation of responsibilities and rights are agreed and documented	Yes	A statement of activities has been submitted and the sponsor is not requesting and does not expect any other site agreement to be used.
4.2	Insurance/indemnity arrangements assessed	Yes	No comments
4.3	Financial arrangements assessed	Yes	No application for external funding has been made. The statement of activities confirms there are no funds available to sites from the sponsor.
5.1	Compliance with the Data Protection Act and data security issues assessed	Yes	No comments
5.2	CTIMPS – Arrangements for compliance with the Clinical Trials Regulations assessed	Not Applicable	No comments
5.3	Compliance with any applicable laws or regulations	Yes	No comments

IRAS project ID	249234

Section	Assessment Criteria	Compliant with Standards	Comments
6.1	NHS Research Ethics Committee favourable opinion received for applicable studies	Not Applicable	No comments
6.2	CTIMPS – Clinical Trials Authorisation (CTA) letter received	Not Applicable	No comments
6.3	Devices – MHRA notice of no objection received	Not Applicable	No comments
6.4	Other regulatory approvals and authorisations received	Not Applicable	No comments

Participating NHS Organisations in England and Wales

This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.
Participating NHS organisations will conduct all study activities as per protocol. The activities will be undertaken by an external researcher. The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England and Wales in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation. Where applicable, the local LCRN contact should also be copied into this correspondence. If chief investigators, sponsors or principal investigators are asked to complete site level forms for participating NHS organisations in England and Wales which are not provided in IRAS, the HRA or HCRW websites, the chief investigator, sponsor or principal investigator should notify the HRA immediately at hra.approval@nhs.net or HCRW at Research-permissions@wales.nhs.uk. We will work with these organisations to achieve a consistent approach to information provision.

Principal Investigator Suitability

This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and Wales, and the minimum expectations for education, training and experience that PIs should meet (where applicable).
A local collaborator is expected at participating NHS organisations GCP training is not a generic training expectation, in line with the HRA/HCRW/MHRA statement on training expectations.

IRAS project ID	249234

HR Good Practice Resource Pack Expectations

This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken
No Honorary Research Contracts, Letters of Access or pre-engagement checks are expected for local staff employed by the participating NHS organisations. Where arrangements are not already in place, research staff not employed by the NHS host organisation undertaking any of the research activities listed in the research application would be expected to hold Letters of Access.

Other Information to Aid Study Set-up

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales to aid study set-up.
The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

Appendix H – Trust Approval

From: [redacted]
Sent: Monday, April 15, 2019 1:35:40 PM
To: Rivett, Emma [redacted]
Cc [redacted]
Subject: IRAS: 257549 [redacted] Confirmation of Capacity and Capability

Dear Emma,

Study title: Working with psychological distress on NHS inpatient wards: A qualitative exploration of staff experiences and the support they receive
IRAS project ID: 249234
Sponsor: University of Essex

I am writing to confirm capacity and capability for the above titled research to [redacted]

This confirmation is based on the HRA approval letter 1st February 2019 and the attached Statement of Activities and corresponding appendix B. The study is considered to be commencing at [redacted] today 15th April 2019.

I have the pleasure of attaching you letter of access to this email. You should inform me when your study has completed so that we can provide you with a close out monitoring form for return, I will also be in touch for interim monitoring purposes.

Should you have any other queries regarding the research here at [redacted] please do feel free to contact me. We wish you every success with your work here at the Trust.

Kind regards,

[redacted]

From [redacted]
Sent: Friday, May 31, 2019 1:02:59 PM
To: Rivett, Emma L [redacted]
Cc: [redacted]
Subject: Confirmation of Capacity and Capability at [redacted] for IRAS :249234

Re: NHS Staff Experiences of Distress and the Support they Receive V.1

Dear Emma Rivett

This email confirms that [redacted] has the capacity and capability to deliver the above referenced study. Please find attached the statement of activities sheet with local information duly completed by us as confirmation that we are ready to proceed with this study.

We are ready now to go with starting this study and look forward to you as sponsor giving us the green light to begin.

If you wish to discuss further, please do not hesitate to contact me.

Best regards

[redacted]

Appendix I – University of Essex Ethical Approval

25 March 2020

MISS EMMA RIVETT
[redacted]

Dear Emma,

Re: Ethical Approval Application (Ref 18012)

Further to your application for ethical approval, please find enclosed a copy of your application which has now been approved by the School Ethics Officer on behalf of the Faculty Ethics Committee.

Yours sincerely,

[redacted]
Ethics Administrator
School of Health and Social Care

cc. Research Governance and Planning Manager, REO
Supervisor

Appendix J – Participant Contributions to Themes and Subthemes

The participant contributions to the themes and subthemes of the analysis are indicated below.

Themes	Subthemes	Participant
Direct Impact of Incidents	Heightened threat system	Jane, Karris, Allie, Isobel, Will, Pete, Sue, Georgia, Lauren
	Feeling emotionally overwhelmed	Karris, Allie, Will, Dan, Georgia, Lauren
	What do I do to help you? The struggle with self-harm	Jane, Allie, Pete, Sue, Dan, Georgia, Lauren
	The worst-case scenario	Jane, Allie, Pete, Dan, Georgia, Lauren
	You're just fighting an uphill battle	Jane, Allie, Sue, Dan, Georgia, Lauren
Attempts to Manage Impact	Defending against the impact of incidents	Jane, Karris, Isobel, Will, Pete, Sue, Dan, Lauren
	Just get on with it	Jane, Karris, Allie, Isobel, Will, Pete, Sue, Dan, Lauren
	You have to remember they're unwell	Jane, Will, Pete, Dan, Georgia, Lauren

Current Systems for Managing	Practical incident management Support systems: Good, Bad and Absent	Karris, Allie, Isobel, Will, Pete, Sue, Dan, Georgia Jane, Karris, Allie, Isobel, Will, Pete, Sue, Dan, Georgia, Lauren

Direct quotes from each participant contributing to the subthemes are indicated below.

Subthemes	**Supporting Quote**
Heightened threat system	**Jane:** "So, that had a profound impact on me. That the patient could s-change in mood quickly. I then sort of realised that I have to be careful-be more careful, you know? One has to be careful because the reaction could just be so sudden. You never can tell." **Jane:** "…it's a lesson to anybody working in an acute ward or working in this kind of setting that there's a flip, the flip could just come up like that. You know, something can just- in their head – attack. You know? One has to learn how to stand, how you behave, to be watching." **Karris:** "…throughout the day I was just a bit wary and like looking over mt back a lot and if I would come out of my office I'd wait to see where she was

first. Erm, and if for example she's coming down the corridor I would probably just wait for her to just walk past and then I would go, because I knew that day she was just lashing out at everyone, erm. So yeah, it wasn't the best environment to work in 'cause you're just very on edge in scenarios like that."

Allie: "…it's a scary-especially because you don't know. You don't know what they're capable of, you don't know their history. Erm, if you do know the history it's still quite scary because you think 'he might do it this time' or whatever".

Allie: "Yeah, and for males I always find it quite, erm, intimidating if like they're very near me, or they're standing about me or if I'm sitting and they're standing. It does make you feel quite intimidated".

Isobel: "It was incident which I was very stressed about and, erm, it affect me quite-quite a lot. For a few days I couldn't even sleep properly."

Will: "I remember one particular time when I was put on the floor by a female patient, who the week had tore a muscle in my arm…so I became slightly wary

of her on the ward…and I'm still wary of this woman. Every time I see this woman I still sort-I can feeling myself going slightly to one side of her."

Will: "It does affect my relationship with hwe. Jut slightly. Erm, and what I tend to do, I tend to sort of, erm, try a little bit more with people like that. 'Cause I know the effect so I try and, you know what I mean? I try and balance my bias if you know what I mean? But there's not that relaxed, erm, relationship and attitude that I think would be therapeutically better."

Will: "There's a sort of like, erm, wariness on my behalf, and when I'm close to her-because it came completely unexpected. Completely out of the blue, and she just 'bang' and hit me, and I hit the floor. It-honestly, if I'd have seen her coming I'd have got out the way, but I didn't. And so when I'm close to her I'm always-anything could happen."

Pete: "When he's up and he's much more himself he says that he'll never hurt me, but I was just mindful of the fact that and any point, you know, just because of where he had gotten to that day, maybe he might. So I was mindful of where I was standing, my positioning

within the team. Sort of standing behind or with the nurses."

Sue: "I've recently had, erm, a lady be quite verbally aggressive towards me, where I actually felt threatened. Erm, so this lady is quite paranoid. She's been following me around the ward quite a lot. She literally come up to me and was screaming in my face. Erm, and she looked so angry. And it was the first time I thought 'wow, I'm in a little room'."

Georgia: "Obviously there's a gender component to it as well, you know. You do feel a little bit under threat because you're of a different gender."

Georgia: "Before he's broke multiple planes of glass in many doors, threatened people saying that he wanted to seriously harm other patients and staff. Erm, and that was in my mind, 'oh gosh, is that gonna be the start of round two of the escalation?'."

Lauren: "I was just dreading going on there and seeing the carnage."

	Lauren: "Sometimes you feel so tense and it puts you on edge."
Feeling emotionally overwhelmed	**Karris:** "Cause a lot of staff go off sick. Erm, there's so many staff that I saw when I first started here that are not here anymore than have gone-got other jobs."
	Allie: "I think you definitely get higher sickness levels. You definitely get the morale just go a little bit when you've got a couple of people-one or two that are showing that kind of aggression. Erm, yeah. So that's a bit difficult, erm, and it's hard to manage a team where you're constantly trying to beg someone to go-'it's gonna be okay, please just come to work, we're gonna move him' or, you know."
	Allie: "…when I came in the morale was just really low, and there was like six or seven people on the shift at the time, and they were all involved. They were all like involved with the SI process, the coroners, and I just know that a lot of them blamed-not blamed themselves, but there's always that question 'what if? I could have done this. Why didn't I do this? Or should I have just checked him that minute?' or whatever it was."

Allie: “I can’t take that feeling away from them. And for that-six months within that time, like, staff were scared. Scared to do anything wrong, scared to make a wrong decision, it was quite sad”.

Allie: “We’re trying to prevent it. Okay, we weren’t able to, and we will learn as a team from that. But people really took it personally, erm, and it’s hard to try and not make them feel guilty, you know. Because they do. So that’s quite a difficult one.”

Will: “I said-basically to my manager, I’m gonna go off sick ‘cause of the stress levels. I can’t cope. I’m crying. I was coming in to work and finding myself crying and having to find a room. I’m going to the canteen over there and crying my eyes out.”

Will: “And we went to this debrief and teo of the nurses were sobbing. The new nurses. And I said, sort of as my little bit, I said ‘you know what, it’s good you’re crying. I said ‘this is the first time-I’ve been here in almost ten years’, I said ‘we have these debriefs, and these debriefs are for people crying. That’s why we have them. And yet I’ve never seen

anyone cry. Ever. Until today'. I said 'so you crying-', I said 'that is a good thing. You're being honest with your emotions rather than holding them back."

Will: "And you get low morale. It affects morale and it also affects, erm, sickness. People just go off sick all the time. I mean all the time. People are just off sick with the stress. Erm, and this isn't necessarily suicide, this is day to day work. You know, it's like, yeah, yeah. Don't come in to work in the NHS if you want an easy life, honestly."

Will: "…it can have profound devastating effects on people. I've seen very, erm, able and capable, good workers, who, who were a shadow of their former selves. In fact I've seen people-I've known people who've left. I know people who are very experienced, fantastic people, fantastic nurses, they've been attacked and they've never, ever come back."

Dan: "When I first started it did have an impact on me back then. Erm, it can be quite overwhelming at times."

Dan: "…if you've been assaulted and you're expected to come back the next day, eventually the person will say 'you know what, I'm not paid enough to get punched, so I'll move on'."

Georgia: "It's tiring, they're complex patients and you can feel quite desperate at times. When they go in cycles especially. Working out what's causing it from their diagnoses to figure out how to approach it. It's tiring."

Lauren: "Obviously she completely dysregulated at me and was like 'I'm going to kill myself. I can't believe you're leaving me alone. This is what happened to all my friends who were admitted, and they've ended up like actually killing themselves'. So I was sitting there like 'I already can't take this', and unfortunately-I'm actually embarrassed about it, I started to cry in front of her, and I had-I didn't cry, I just had tears in my eyes and I couldn't control them coming down. So I had to stop the session and be like 'you need to give me an hour', and I was just completely-I had to go in the toilet and have a complete and absolute breakdown."

What do I do to help you? The struggle with self-harm	**Jane:** "Why do you want to do that? It is what's going on in their head, you know? And we are not in their position, we don't know much about it." **Jane:** "Why would you want to kill yourself? Why will you wanna kill yourself? That kept coming to my mind. I kept saying, you know, I make a sigh to myself I say 'mmhmm'. That kind of sigh. I said 'why?'. You know? I just can't imagine, you know?" **Allie:** "Like, he wasn't aggressive towards me, but he was just trying to harm himself. Was just really fixed on harming himself. Erm, that was quite hard. I find that quite difficult. I'm not very good at that. De-escalation, violence and aggression, I got that. But that I'm just like 'what do I do to help you?'." Allie: "It made me feel really sad that this person's in hospital, he's under my care, and he felt like he needed to do that…so I kind of felt like a bit of a failure." **Allie:** "…that was kind of upsetting 'cause I know him really, really well-for years. And I just couldn't

understand what we'd done to make him feel like he needed to do that."

Pete: "I guess it was, erm, concern, erm, because I saw this patient when he first came in. I've seen his journey. I've been seeing him for various reasons over time and he's never expressed these kind of thoughts or behaviour-or exhibited any of these types of behaviours. So it was concern, a little bit of surprise, erm, wondering why it happened on that particular day".

Sue: "I thought 'you're going to kill yourself', like 'you're gonna die'. Like, what do you do with that? Like where do you go with that if somebody kills themselves?"

Dan: "It took me a few seconds to realise what was happening, because obviously I was in, I was in a fun, playful mood playing table tennis with the patients, and out of nowhere he just comes up and says to us I need to go to hospital I've cut my wrists, er, I'm gonna die. And obviously-I looked at his wrists and looked at him for like five seconds, and then eventually we snapped out and said okay. My

colleague took him to the treatment room and I called the doctor and we dealt with it. But we didn't know why he did it. I don't know if he would do it again."

Georgia: "I think it's quite tiring for them because they're more psyched up for aggression. You know, their modality is aggression, we can deal with aggression easier. It's easier, we can just put them in seclusion, we can medicate them, we can wait, the psychotic episode will end."

Georgia: "I think you have to be so much more psychologically minded, containing, erm, you know. Constantly providing hope, you know? Encouraging-even though they're probably thinking 'oh my god, this is never gonna change', you know, they probably felt quite desperate at that time. But maybe when the patients are aggressive-some of it is actually about basic nursing needs isn't it? Feeding the patient, helping them, you know? Nursing them in a kind of more direct, general nursing kind of way. And that might feel a bit more comfortable to them."

Lauren: "Um, 'cause on the ward this year two incidences have occurred where people have killed

	themselves…and I can't do anything about it, and it's too much. And I thought 'it's gonna happen again now', and it's like 'no'. I felt I wasn't fit at that moment in time to be doing anything for anyone."
	Lauren: "I was so worried about her, but what can I do? I can't stop her. How can I help her? Are people on the ward taking her seriously?"
The worst-case scenario	**Jane:** "Could you imagine if you were the one given the task to go round-because we do every hourly. And whilst you were doing that you had a mind to say-something said to you 'go in and check'. And the other mind says 'you don't need to disturb his sleep'. It's your decision. It's a decision you make that moment. And you look, you look at the pigeon-because they've got like a pigeon hole. You look at it, and you see some of them, they've covered their body but you will see the movement of their breathing in there. And then you say 'oh he's sleeping'. And meanwhile he's making an attempt to take his life. And you don't know. Just imagine if you make that judgement. That error in judgement and say 'oh he's alright, he's just sleeping, I won't wait'. And then

somebody goes there an hour or two later and found that."

Jane: "Erm, it might just be the fact that it was a drink that got poured on me, but it was the fact that I wasn't expecting it. And I said 'oh my god. If it was very hot this might have scarred my face or something', you know? That was frightening."

Jane: "But this thinking is of 'thank God' of that kind of-saying to myself-saying 'at least I came out unscathed, nothing happened to me'."

Allie: "I was glad I was there in a way 'cause I knew I could talk to him and-it could have gone a lot worse I suppose."

Pete: "He didn't have to come and tell us. He could have just done it in his bedroom while no one was watching. I was relieved he didn't."

Dan: "…and the worst thing is-like I said about the aggression, we deal with it on a daily basis so it's not something that affects me personally. But the self-harm and the suicide attempt is something that will

stay because we don't deal with that kind of stuff on the ward. We've never had somebody cut their wrist on our ward."

Dan: "I don't think of the situation as it was, I think of the worst-case scenario. If he had died. If he had cut himself in his room and then left it to bleed to death rather than come to us for help. Even amongst staff we talk about it, we said it could have been much, much worse. He could have cut himself and obviously bled to death rather than come to us. It's better ger came to us rather than us finding him in that state. Or it could have been a very, very bad day for everyone."

Georgia: "You know his history, he's been moved from several wards because he's trashed the place. Broken doors and windows and assaulted staff. And you see him going, and he's not long been out of seclusion, and you're thinking 'do we have to do this again?'."

Lauren: "I was so worried about her, but what can I do? I can't stop her. How can I help her? Are people on the ward taking her seriously?"

	Lauren: "This girl, she had a history and I feel like that went against her. But it was a bad day and her wounds were pretty deep. I was worried. What happens if she kills herself, too?"
You're just fighting an uphill battle	**Jane:** "…they might not react but their attitude to work might be different. You see? So they might not- for example, if they were doing like ten tasks complete, they might decide to do like six or seven…I'm not saying that's what I'm doing, but that might happen as well."
	Allie: "We have gotten better at managing the incidents but we can't stop them. And I have to keep begging staff to come in, to work on this ward. But they're tired and stressed and it gets harder each time."
	Sue: "You know they're going to do it, and you can't stop it. They always find a way to, even if you think you've taken it all from them, they'll have something. And that's a battle".

Dan: "But if you've been assaulted and you're expected to come back the next day, eventually the person will say 'you know what, I'm not paid enough to get punched, so I'll move on'. And recently we've had five or six staff left the ward in the space of three months. So I think people are-when people do get fed up, they move on."

Dan: "For me it's like I said, it's just I deal with it, I'm used to it, tomorrow's another day. If it happens, I'll deal with it again…If I see an incident happen on the ward it's just part of the job. It's happened too many time and now you look at it as if it's just anything-another day."

Georgia: "It's really hard for the ward staff, to keep facing these behaviours every day. They don't get a break from it. Its day after day with little change."

Georgia: "The staff are resilient but you can see it has an effect on them. They work well together but its very strategic. They have close guidelines to follow to keep it under control. Things escalate quickly on the ward and you can't always predict it."

	Lauren: "…you're just fighting an uphill battle and it can completely just tire you out and exhaust you, and you just lose that drive I had at the beginning-at the start of this job, like 'oh maybe this. Go, go, go, go'. And then it's just reducing over time, like 'maybe don't go. Just accept it how it is, I can't do much and it's starting to affect me now, so I just need to pull back' kind of thing. Which is a shame for them then, 'cause I don't try as much because I'm like-yeah, it's kind of demotivating actually. **Lauren:** ". Unfortunately you have to like hit that point which you're like 'okay, everything I'm doing is not working', and like-I just started to avoid going on the ward even. I would sit in the library and do work, which is not my role."
Defending against the impact of incidents	**Jane:** "I didn't allow that to impact me too much. The reason why it didn't impact me too much because I was now being grateful to God. I was now saying 'thank you whoever is looking after me over there'." **Jane:** "I didn't have time to think about it, because we finish the shift at eight o'clock in the morning, you get home, you try and have your few hours sleep and

you're back in the ward again. I don't think about it. I can't."

Karris: "Erm, well I go to the gym every day. Monday to Friday. So I did that, and that was really helpful that day. Erm, I do find the gym often does help a lot when I've had like difficult days at work."

Isobel: "…as long as I know I've done everything what I have to do. I've completed-I kind of cover myself thinking that, erm, everyone is safe now and I can go home, I'm fine. 'Cause I'm now trying to leave work. Work is work, not for home."

Will: "I go home and I've cried my eyes out like. At home. Erm, I go straight to the pub, you know what I mean? Go straight to the pub. Go get drunk."

Pete: "I was worried, initially. I hadn't seen this before. But I handed it over to the next doctor and staff so I was okay then. I dealt with it and passed it on. I could go home."

Sue: "I think they just defend against it. We were talking and someone said 'oh I would just deal with it', and I thought 'no, I don't think you will actually'."

Dan: "Usually when I'm at work I don't think about home. When I'm at home I don't think about work. Once I've left that place it's over."

Dan: "I think it used to affect me, but I'm used to it now. I've been here so long it doesn't affect me anymore, I think of it as part of the job."

Lauren: "…these things that I teach them to do I wasn't even doing myself. Good, hypocrite over there. Yeah, so just doing those things. Just the simplest of things like yeah please continue exercising because you really do need to do that."

Lauren: "…keeping a work life balance is absolutely vital. Leaving on time, vital. All these small things make a massive difference. Which I learnt a bit late but-learned them."

Just get on with it	**Jane:** "You just carry on regardless. You think, 'well if anything happens nobody cares anyway', so you carry on"
	Karris: "…it's probably not a good thing but you kind of become immune to it after a while-self-harm, like, hearing about really horrible abuse. Erm, just having to get on with it after being verbally abused by a patient every day. Erm, you kind of just become immune to it."
	Karris: "I guess everyone just kind of gets on with it really. That's the work culture."
	Allie: "I think I've become quite complacent on the ward and become quite used to managing violence and aggression. A few years ago it would make me feel very scared and anxious and just not knowing-just yeah, just really like scared. Whereas now- I just feel like I'm able to manage."
	Isobel: "…we could be a bit ignorant you know, if it happened. I know-some staffs are very sensitive even to verbal aggression. Erm, but I think we ignore that.

Because we probably think if I'm handling that you also have to learn how to handle that."

Will: "…before you work in an environment like this where people kill themselves regularly, you sort of like-suicide is a shock isn't it? It's always a shock, but you get used to it quite quickly. And I got used to it quite quickly. After a few months someone said 'blah blah is dead', and you sort of go 'oh'. It's an initial shock and then five minutes later you've forgotten about it."

Will: "You just have to get on with it. I mean that, I mean that is-I don't necessarily agree with it, with that sort of approach to nursing or OTAing or whatever. But there is-in some elements, in some ways I do…at some point during people's admission, or you know-that is probably a slight exaggeration, you're gonna get either verbal abuse. You're gonna get physical abuse. You're gonna get-that will happen. So you need to be thick skinned."

Will: "…on the wards there's a sort of macho type approach to not talking about suicide, self-harm. You have to laugh it off. You have to, because-I've heard

it said, and this is not my experience, but I've heard other people saying that if management see you breaking down then you're sort of in trouble. Not in trouble as in you get a warning, but they'll say 'she's weak. He's weak. Get them out."

Will: "…you can't let it impinge on your professionalism and your-the fact that you work in a psychiatric unit. An acute psychiatric unit for people who are profoundly unwell. You're gonna get suicides. So if you can't handle it, you won't last long. You won't last long."

Will: "…when I was sort of taken in to the staff room, you know off the ward in to the office, erm, people asking me 'are you okay?' blah, blah 'you know, she's very unwell', blah, blah, and then 'okay, back on the ward'."

Pete: "People carry on, particularly those who are involved and probably more front line. I know even when, erm, the nurse in charge and the deputy ward manager were speaking he was definitely more racially abusive to them, but you could equally tell that they similarly weren't taking it too personally."

	Sue: "You see it so much, you just have to deal with it, do a Datix and move on to the next."
	Dan: "For me it's like I said, it's just I deal with it, I'm used to it, tomorrow's another day. If it happens, I'll deal with it again…If I see an incident happen on the ward it's just part of the job. It's happened too many time and now you look at it as if it's just anything-another day."
	Dan: "You have to be tough because we choose to be in that environment so if you're not gonna be tough you're not gonna make it."
	Lauren: "Or being like, weak, from not coping. That's a massive thing on my ward. Being weak. That's not allowed almost. You have to be strong and tough. Like a prison guard. Like 'oh if these things affect you, they shouldn't though'. Even though they're quite horrible things."
You have to remember they're unwell	**Jane:** "They are so unpredictable. They are talking to you, being friends with you. I've had an incident where…he was aggressive towards other people and I

got there and I was thinking ‘oh well, I talk to him it will be fine’-he wasn’t. the state he was in, he didn’t recognise nobody, that was the state that he displayed. He couldn’t even care that it was me…so, it’s a lesson to anybody working in an acute ward or working in this kind of setting that there’s a flip, the flip could just come up like that.”

Jane: “You know, when he gets better. You could tell he was very unwell and all of that, so.”

Jane: “But you could tell that it was because he was very unwell. That was why he done that.”

Jane: “…it tells me these patients are unwell. You can’t predict what they can do.”

Will: “…you need to be thick skinned. And you need to remember they’re unwell.”

Will: “…she has sort of attacked me-not physically attacked me, but verbally been right in my face a few times. And this woman is very unwell.”

Will: "…when I was sort of taken in to the staff room, you know off the ward in to the office, erm, people asking me 'are you okay?' blah, blah 'you know, she's very unwell', blah, blah, and then 'okay, back on the ward'."

Will: "There was a short interview with the police the next day and they said she won't be getting prosecuted 'cause she's under section, and I said I'm happy with that. I understand that. She's very, very unwell."

Will: "…when she's very unwell she can be a challenge. So I don't take it personally."

Pete: "…probably more at the time just realising that he's just having a bad day, he's just not well on that particular day, erm, the he will later remember this and probably apologise for it."

Pete: "There probably wasn't enough time to stop and really think, except for probably what I was thinking at the time which was 'he's unwell now, erm, I'm sure by tomorrow he will be hopefully sort of a different person'."

	Dan: “Our patients can be very unwell. And then you know they’re gonna need medication and time and then they’ll be better for it.”
	Georgia: “After an incident staff can start ruminating about it in a kind of not that helpful way. It can sometimes take away from the fact patients are clearly unwell:”
	Georgia: “He has a cycle. He comes in, he gets better, he absconds and uses drugs, comes back unwell and hostile. And you know he will get better again, but then the cycle continues.”
	Lauren: “Sometimes staff don’t understand their behaviour. I mean, that’s just one person who’s severely mentally unwell right now. They don’t need judgment they need understanding.”
Practical incident management	**Karris:** “Yeah, when incidents happen it’s-I think the emphasis-the highlight is focused more on the incident and like we don’t wanna be seen as like a bad ward, because there’s so many other wards here as well, and we don’t want tp have so many serious

incidents and stuff like that so that's where-that's the important part really".

Allie: "But there's some incidents where there's literally like nothing-that person is just a very angry person at the time, and there's very little you can do to try and minimise that".

Allie: "…overall I think the team in general have used a lot of Safewards and things like that to reduce violence and aggression. Which is really good."

Isobel: "We know what to do. Verbal de-escalate, check for injuries, do a Datix. We do all that."

Will: "…but it was sort of not managed. It wasn't managed. It wasn't managed at all."

Pete: "We felt we couldn't manage him-just the nurses and myself, so we had to call the sort of psychiatric emergency team, which is made up of a unit of more nurses, to come and assist. He was, erm, he's quite a large gentleman. Quite tall. Quite intimidating. Erm, he needed a lot of, erm, encouragement, prompting. And then we had to

medicate him to try and lower his level of aggression down. It took maybe 45 minutes or so until that level came a level which we could manage."

Pete: "I think we managed it well. Not all of us went in, we weren't sort of overcrowding him. Just enough to ensure that everyone was safe."

Sue: "We have the procedures on the ward. We know what to do when an incident happens. There's a team we can call for help. You have to do the Datix, even for verbal aggression you should really. Just make sure there's a paper trail."

Dan: "Very often you have patients being aggressive and violent towards other patients and staffs, and obviously we have seclusion, where we have to seclude that person to manage the risk to themselves or others."

Dan: "But a lot of times-the patients we're receiving, when you talk to them, they listen, unless they're very, very unwell. But most of the time we try to use verbal de-escalation rather than physical. So, our physical restraints have gone down a lot compared to

	previous years. So-'cause staffs now are using more, like I say, Safewards interventions. So, we're not having to restrain that much."
	Dan: "I love working in a PICU [Psychiatric Intensive Care Unit] because we do-I believe all of us do a good job, because when we receive the patient's they're at their worst. Very aggressive. Very manic. But then after a few weeks you see them in a different presentation. Very calm and interacting with us, so that gives you that satisfaction you know? It reminds you why you started that job in the first place."
	Georgia: "They work well together but it's very strategic. They have close guidelines to follow to keep it under control."
Support systems: Good, Bad and Absent	**Jane:** "…doing a Datix. Nothing came out of it. Nothing was done. Nobody approached me. I just had to deal with it myself. So that was it."
	Jane: "that was the help I got. That-my shift-from my colleagues. I didn't have to be with that patient until the shift was ended so that was a massive support."

Jane: "…you can only know the impact if you find out more from the staff member. It might even be an incident that is not as serious as that but it might have a serious impact on that staff member. It depends on the individual, you know, and how the individual takes stuff."

Jane: "It's not any good saying 'we acknowledge it', erm, there has to be some sort of follow-up."

Karris: "…throughout the whole day staff was just very-just like helpful. Always asking 'do you need a break? Do you wanna go on your break? Have you had your lunch yet?'. 'Cause we know it was quite a difficult day at work so it was important to kind of get off the ward and go and have a break".

Allie: "We do reflective practice on the ward, but really you won't come if you're not on shift. No-one's gonna come in for an hour from their day off. You're only gonna come when you're on shift. And even that you're not in the mind to reflect and talk about reflective practice."

Allie: "…overall it is a very difficult area to manage and support because for me, personally, I never know what to say. What do I say to a grown man that's been hit? For me I'm like 'oh are you okay?'. For a woman I'm a bit better. You kind of can put things in place, but for a man they're already kind of got that manly kind of 'I'm okay' and I feel like I can't support them or cuddle them and things like that."

Isobel: "First you discuss with the team, you know? Erm, and if you need further support, you know, you would probably approach your line manager. And our line manager's quite good with that."

Isobel: "I think it should be more protected time, but again on the busy ward it's less likely to happen."

Will: "I tell you what did affect me, actually…it was reported to the police. Because it was a physical attack. And then the police turned up the next day to interview me, and the policeman thought it was hilariously funny. And he said 'we've all been laughing about this back at the, er, back at the thingy'. And he was saying 'wehre abouts between your legs?' and he was making a joke about it. And that I found-at

the time I was trying to laugh it off, I think I was trying to be a bit macho about it. But part of me was thinking 'fucking hell mate. If I see someone attack you in the street I wouldn't be making jokes about it'. It was as if-the sort of, what's the word? The erm, the sort of investigation was all wrong."

Will: "…whenever I went to speak to a manager they were always available. I don't wanna say that, erm, I was treated badly. I wasn't. I was actually treated very well. On a personal level they couldn't have been more supportive."

Will: "It's everyone, erm, that can make bad decisions or can say insensitive things. They can do insensitive things.. Professionals have to be really attuned to the feelings of people around you. Whether they're HCAs, cleaners, doctors, you have to be attuned to everything, because some of the worst things that can happen, or be said to you are by your colleagues."

Pete: "I guess in my situation it is slightly different because I am supervised by the consultant on the ward, so I guess if I have any issues or if something

like this were to happen and I wanted to raise it with him, I could raise it with him that day or at my supervision, which I have with him. Erm, so I think it's implied support. There was nothing formal following that, erm, I think partly because these types of incidents happen quite frequently."

Sue: "I've stood there and one will be shouting at me 'I wanna be dsicharged' and another will be shouting at me 'I want cigarettes', and then all three of them shouting and wanting things…And I'm standing there thinking 'okay, anyone else gonna come out and speak to these patients with me? Or am I just gonna try and hold all three of them?'. So I kind of find that a bit frustrating."

Sue: "I think I come from a very open team, very supportive team, and we talk about it, talk about experiences."

Sue: "I always felt very kind of supported and safe."

Dan: "All you're asked to do it complete a Datix and that's the end of it."

Dan: "The way I handle the situation is different to how somebody else might handle the situation…I think there should be more support. I don't know what kind of support, but I think there should be. I feel like staffs, and patients as well, when they go through traumatic experiences of just being assaulted, or experiencing stuff like attempted suicide or self-harm, there should be a little bit of support for them. For them to express themselves and make sure that they're mentally healthy and ready to work. 'Cause a lot of times people stay quiet and no-one say anything, but it's there, it's affecting them."

Georgia: "I think they do work well together, they're supportive, erm, you know, they will challenge each other."

Georgia: "I think more kind of reflective practice groups across MDTs would be helpful, because obviously the groups I attend are only for medics of a similar grade. There's a difference, erm, when you're as a team doing something. But then I don't know 'cause that might have it's problems as well. Maybe some of the people who have been here for a long time would just set the narrative of how these kind of

reflective groups go and new people who are kind of coming in and out don't actually have space to kind of share."

Lauren: "No. there's no debrief for them. There's-I will go up to them and ask like 'are you okay?'. They get shocked when I ask them that…No-one, I don't think, asks them. No-one asks me at the time, but I can reflect on it in supervision. I'm in that position where I can do that."

Lauren: "On my ward debriefs don't occur-even after serious incidents that don't happen. And that is ridiculous."

Lauren: "I think they definitely need more support and space to like reflect and think. I don't know how they'll get it. Their demands are just too high. It's like there's no room. Even in team meetings-we have monthly team meetings. The attendance is low. 'Cause the staff are needed on the floor and we don't book any other staff."

Appendix K – Interview Schedule

Incident Details – Violence and aggression

1. Please think of a time where you were exposed to a patient displaying violent or aggressive behaviour whilst at work. Please share what you remember of this incident in as much detail as possible.

Prompt, if required

How long ago did the incident happen?
Under what conditions did the event occur? (Random target, had been on patient's observations, had been assisting another member of staff etc).
What was going through your mind at the time? How did you feel? What did you do to cope in the moment?
The outcome for both patient and staff

Incident management details

1. Please describe in as much detail as possible how the incident was managed at the time. What do you think was done well? What could have been done better? Did any training needs arise from the incident?

Personal management details

1. Please describe in as much detail as possible how you personally managed the incident after it occurred. Was time taken away from the shift? What coping skills were used once the shift had ended?

Impact of experience and support

1. Thank you for sharing this with me. How do you think the incident impacted on you personally? On your work? On your interaction with clients? On the staff team?
2. What support did you receive following the incident? From who? How soon after the incident happened?
3. Were any of your needs unmet following the incident? If so, which, and how could this be addressed?
4. If support was received, what was good about it? What could be improved? If support was not received, what would have been helpful at the time?
5. Is there anything else you would like to share about the incident?

Incident Details – Self-harm and suicide ideation

1. Please think of a time where you were exposed to a patient displaying violent or aggressive behaviour whilst at work. Please share what you remember of this incident in as much detail as possible.

Prompt, if required

How long ago did the incident happen?
Under what conditions did the event occur? (Random target, had been on patient's observations, had been assisting another member of staff etc).
What was going through your mind at the time? How did you feel? What did you do to cope in the moment?
The outcome for both patient and staff

Incident management details

1. Please describe in as much detail as possible how the incident was managed at the time. What do you think was done well? What could have been done better? Did any training needs arise from the incident?

Personal management details

1. Please describe in as much detail as possible how you personally managed the incident after it occurred. Was time taken away from the shift? What coping skills were used once the shift had ended?

Impact of experience and support

1. Thank you for sharing this with me. How do you think the incident impacted on you personally? On your work? On your interaction with clients? On the staff team?
2. What support did you receive following the incident? From who? How soon after the incident happened?
3. Were any of your needs unmet following the incident? If so, which, and how could this be addressed?
4. If support was received, what was good about it? What could be improved? If support was not received, what would have been helpful at the time?
5. Is there anything else you would like to share about the incident?

Thank you for taking part in this interview. Is there anything else that you would like to share with me that we might not have covered today?

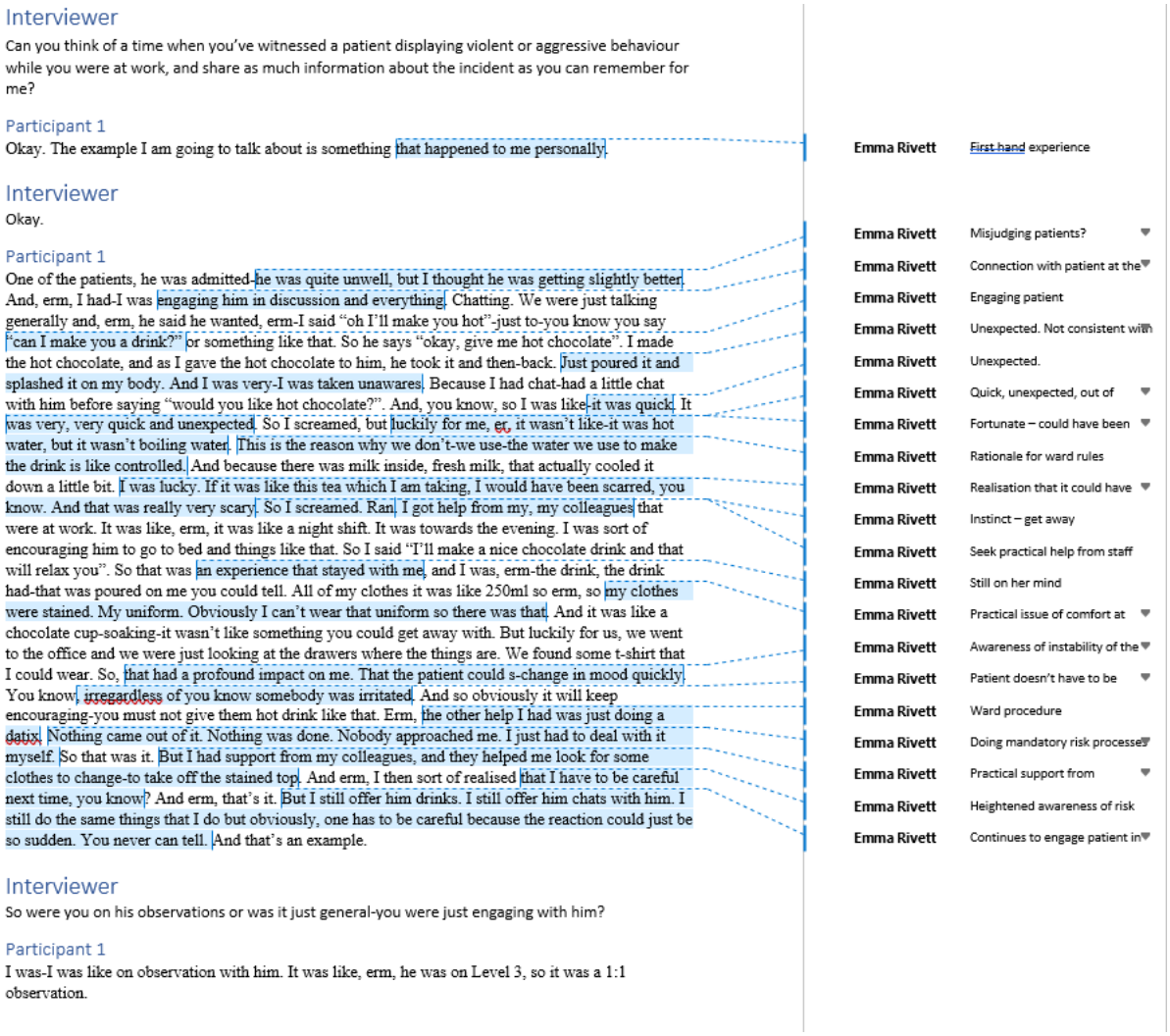
Debrief.

Appendix L – Participant Demographics Form

Participant Demographics (can be determined prior to interview)

1. Gender
2. Age
3. Ethnicity
4. Profession
5. Job Title
6. Years of employment in inpatient settings
7. Years of employment in current role

Appendix M – Example of Transcript Coding



Interviewer

Can you think of a time when you've witnessed a patient displaying violent or aggressive behaviour while you were at work, and share as much information about the incident as you can remember for me?

Participant 1

Okay. The example I am going to talk about is something that happened to me personally.

Interviewer

Okay.

Participant 1

One of the patients, he was admitted-he was quite unwell, but I thought he was getting slightly better. And, erm, I had-I was engaging him in discussion and everything. Chatting. We were just talking generally and, erm, he said he wanted, erm-I said "oh I'll make you hot"-just to-you know you say "can I make you a drink?" or something like that. So he says "okay, give me hot chocolate". I made the hot chocolate, and as I gave the hot chocolate to him, he took it and then-back. Just poured it and splashed it on my body. And I was very-I was taken unawares. Because I had chat-had a little chat with him before saying "would you like hot chocolate?". And, you know, so I was like-it was quick. It was very, very quick and unexpected. So I screamed, but luckily for me, er, it wasn't like-it was hot water, but it wasn't boiling water. This is the reason why we don't-we use-the water we use to make the drink is like controlled. And because there was milk inside, fresh milk, that actually cooled it down a little bit. I was lucky. If it was like this tea which I am taking, I would have been scarred, you know. And that was really very scary. So I screamed. Ran. I got help from my, my colleagues that were at work. It was like, erm, it was like a night shift. It was towards the evening. I was sort of encouraging him to go to bed and things like that. So I said "I'll make a nice chocolate drink and that will relax you". So that was an experience that stayed with me, and I was, erm-the drink, the drink had-that was poured on me you could tell. All of my clothes it was like 250ml so erm, so my clothes were stained. My uniform. Obviously I can't wear that uniform so there was that. And it was like a chocolate cup-soaking-it wasn't like something you could get away with. But luckily for us, we went to the office and we were just looking at the drawers where the things are. We found some t-shirt that I could wear. So, that had a profound impact on me. That the patient could s-change in mood quickly. You know, irregardless of you know somebody was irritated. And so obviously it will keep encouraging-you must not give them hot drink like that. Erm, the other help I had was just doing a datix. Nothing came out of it. Nothing was done. Nobody approached me. I just had to deal with it myself. So that was it. But I had support from my colleagues, and they helped me look for some clothes to change-to take off the stained top. And erm, I then sort of realised that I have to be careful next time, you know? And erm, that's it. But I still offer him drinks. I still offer him chats with him. I still do the same things that I do but obviously, one has to be careful because the reaction could just be so sudden. You never can tell. And that's an example.

Interviewer

So were you on his observations or was it just general-you were just engaging with him?

Participant 1

I was-I was like on observation with him. It was like, erm, he was on Level 3, so it was a 1:1 observation.

Emma Rivett	~~First hand~~ experience
Emma Rivett	Misjudging patients?
Emma Rivett	Connection with patient at the
Emma Rivett	Engaging patient
Emma Rivett	Unexpected. Not consistent with
Emma Rivett	Unexpected.
Emma Rivett	Quick, unexpected, out of
Emma Rivett	Fortunate – could have been
Emma Rivett	Rationale for ward rules
Emma Rivett	Realisation that it could have
Emma Rivett	Instinct – get away
Emma Rivett	Seek practical help from staff
Emma Rivett	Still on her mind
Emma Rivett	Practical issue of comfort at
Emma Rivett	Awareness of instability of the
Emma Rivett	Patient doesn't have to be
Emma Rivett	Ward procedure
Emma Rivett	Doing mandatory risk processes
Emma Rivett	Practical support from
Emma Rivett	Heightened awareness of risk
Emma Rivett	Continues to engage patient in

Appendix N – Reflective Journal Example

Interview One

Pre Interview: Feeling a little nervous – staff on the ward appeared supportive and welcoming but many mentions about being busy and difficulties about coming off shift. Ward Manager has been encouraging and supportive, feels it's important for staff to share their experiences to make changes, which feels encouraging.

Post Interview: Participant had a lot to share and was very open with her experiences. Appeared very down to earth and sensible, and I wondered how this might come across on the wards with her colleagues and patients she works with. Sometimes found it difficult to bring participant back to the questions once she had started going off on a tangent – trying to find the balance between elaboration on their experiences and ensuring the questions get answered to cover all bases. Found it difficult at times to remain a neutral stance, and had to keep a check on my non-verbal behaviours (head nodding especially) in response to participant answers. Was aware that I didn't want to look like I was agreeing or disagreeing with what had been said. Felt like the interview lasted a good amount of time (35 minutes) but also worried this wasn't in the expected 45-75 minute frame – did I ask enough questions? Could I have prompted the participant to elaborate more? Also aware of my own preconceived ideas – that everyone will have been exposed to self-harm/suicide ideation. Not the case for this client, who could think of incidents that had happened on her ward but that she had not been physically present for – impacting on interview time as little then to think about from this perspective. Overall feeling positive in completing first interview, and making tweaks to how I conduct myself for the next one.

Appendix O – Thematic Analysis Process

Adapted from Braun and Clarke (2006)

Phase	Process
1. Familiarising yourself with the data	Transcribed the data by hand, listening through tapes once for initial transcription, again to make changes to transcription and to capture anything missed, and a third time to check for accuracy. Made notes of initial ideas as they arose.
2. Generating initial codes	Systematic working through the data identifying and coding interesting segments. Use of Nvivo software to help with this and keep track of coding withing and across the data sets.
3. Searching for themes	Used Nvivo to sort codes in to different potential themes. Thought about different levels of themes and relationships between themes.
4. Reviewing themes	Went over themes and reviewed if the data supports them. Identified if they are a stand alone theme or a subtheme. Checked themes in line with the wider data set to ensure they were accurate and reflective of the data.
5. Defining and naming themes	Identified suitable names for each theme and subtheme. Ensured appropriate narratives supported the themes. Thought about how the themes related to the aims and research questions being asked.
6. Producing the report	Ensured quotations were appropriate and best placed to show evidence of the themes and subthemes. Themes used alongside narrative discussion to offer context and insight